Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 37001 State of Maryland / Department of Health and Mental Hygiene 2 [ For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Timothy Wayne Roach 9:50 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll Taneytown 36 Musket Court . Social Security Number if Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral (Month, Day, Days 1 XM 2 - F 1953 57 217-62-1389 Marvland Director Usual Residence of Decedent "natural", or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Carroll Taneytown 1 X Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21787 36 Musket Court USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 

If Yes, Give Black, White, etc 1 Never Married 2 Married Completed by 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland 12 Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Elnora Mullan Lloyd Roach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36 Musket Court, Taneytown, MD 21787 Marquerite Roach, wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 DOther (Specify) St. David's Cemetery 11/01/2011 Hanover, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral 136 E Baltimore St, Taneytown, MD 21787 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Drostede metztzhi disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Completed by Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director; page 2 should be detached for use as the human. that initiated events Due to (or as a consequence of) resulting in death) Last P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 = No ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate; 28b. Time of 28c. Injury at 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier WJL 43643 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAN EYPOUN, MARTLAND 76 FREDERICK STREET A. TATE JASUN

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death Physician/ November 2011 William Houser Redden 9:35 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert 11450 Asbury Circle, Apt. Solomons Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7, Age (In yrs. last birthday) Funeral 1 № M 2 🗆 F Months Days Hours Texas Director 463-03-3026 93 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛂 No Maryland \_Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 11450 Asbury Circle. 20688 Apt. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give þ Baltimore, Maryland 21215-0036 1 Yes 2 No White Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Assistant Chief Metalurgist Steel Plant 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Kela Houser Hubert Redden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Solomons, MD 20688 11450 Asbury Circle, Apt.326, <u>Margaret F. Redden / Wife</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus 11/05/2011 4 Donation 5 Other (Specify) Baltimore, MD Cemetery . Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. P.O. Box 600, Lusby, MD 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to for as a consequence of the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 No 1 🗌 Yes |@ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practionar To the best of my knowledge. diet the time ideto and place; and due to the cause(s) and manner as sea. 29b. Signature and title of certifie 29c. License number mpleted cause of death (Item 23a) (Type, Pont)

dru 4
State

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 21 per FH G921 11/22/11 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar 37003 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month DORIS Malisa Rudisill 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Julia Manor Healthcare Center Washington H agerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F Hours 215-20-7720 Director 86 Maryland Usual Residence of Decedent or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director traumatic event, the Medical Examiner must be notified Maryland Washington County Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 811 Salem Ave. 21740 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Presser Laundry Co 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles A. St. Clair Mary A.D. Hall St. Clair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy L. Stone-daughter permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to once, 811 Salem Ave. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Cedar Lawn Mem. Park 11-7-2011 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home Douglas A. Fiery per DVR Eastern Blvd. North Hagerstown. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Atherosclerati Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hyperlipidemia, Hypothypoid steparthrits 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director, After this certificate or ompleted filled in by the fur eral director, pag 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔀 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. R125360 11/03/2011 CZ Name and address of person who completed cause of death (Item 23a) (Type, Print) CANP-333 Mill Street, Haverstown, MD 21740 3 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Reeder Linwood Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Washington Meritus Medical Center Hagerstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 - F Months Days Min Director 74 Maryland 219-34-7436 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Maryland Washington Boonsboro ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral Appletown Road 21713 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married <u>چ</u> Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify: White Completed Decedent's Education 16a. Decedent's Usual Occupation المريبة. Aal Hygiene. Aer than 'r 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Dairy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ra1ph William Reeder Mabe1 Mary Poffenberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health ar Important; if item 27 is any injury or are <u>Mary Lou Reeder/Wife</u> Appletown Road, Boonsboro, Maryland 21713 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/06/2011 Boonsborg Maryland Grove Cem. Signature Funeral Service Licens 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike, Boonsborn Maryland 21713 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) asperation Medical Due o (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 ast IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes ≥ L 9 ☐ Unknown been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page performed' this certificate 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural (Month, Day, Year) 5 Pending thin 24 hours after death.

the Funeral Director: After minimizer of the function of the funct Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) edenet

MID

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1- For State Registrar	Certificate of	Health and Menta Death		eg. No. 2011 3	3700		
Physici al Exam		1. Decedent's Name (First, Middle,Last)  Willie Reid, Jr.			2. Date of Dea Month October 3	Day Year			
		4a. Facility Name (if not institution, give street and number) Civista Medical Center		b. City, Town, or Location of La Plata		4c. County of Death Charles			
Funeral Director		165-64-0541 1XM 2F	e (In yrs. last birthday) 43 Yrs.	If Under 1 Year If Under Months Days Hours	Min	rth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) PA			
Maryland 28a-f show any d at once.	tor	Usual Residence of Decedent  10a. State  10b. County  MD  Charles  10e. Street and Number	10c. City, Town or Location Waldorf				e City Limits		
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hygiene Department of Health and Mental Hygiene Martural?, or items 23a or 28a-f sho Importure! If item 71 is marked other than "natural?, or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once,	Funeral Director	4696 Manito Court  11. Marital Status    Married   Armed Forces?   Armed Forces?		20602 s Decedent of Hispanic Origines, specify Cuban, Mexican, I	n? ( Specify Yes or No	USA	Black,		
n 72 hours after d an "natural", or ical Kraminer m	Completed by Fi	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12) College (1-4 or 5	pleted) 16a. Decedent	Yes 2 X No specify: 's Usual Occupation (Give kings) st of working life, DO NOT u y Assistant F	se retired)	Specify: Black  16b. Kind of Business/Industry  Federal Govt.			
l be filed withir ental Hygiene. nrked other th vent, the Medi	Be Comp	17. Father's Name (First, Middle, Last) Willie James Reid, Sr.	Manag	Ramon	Name (First, Middle, M	Maiden Surname)			
2 should and Me 27 is ma matic er	ို	19a. Informant's Name/Relationship (Type, Print) Ruth Riley/Sister		· ·		nber, City or Town, State, Zip Code) apeake, VA 23321			
ages 1 and 2 and 5 and 6 and 6 and 6 and 6 and 7 and 6 and 7		20a, Method of Disposition  1 Burial 2 Cremation 3 Removal from Sta	20b. Place of Disposit	tion (Name of cemetery, er place)	Date 11/7/2011	20c. Location - City or Town, State	9		
permit. r Departme Importar injury or		140, 25 Esale	)945   <sup>22.</sup> N	ame and Address of Facility REHART-ECHOLS	FUNERAL H	IOME, P.A. 20646			
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within 24 hours after death.  To the Functard Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bit.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcom 1 Live birth 4 Pregnant at t	2 Fets	al death 3 Ectopic per (Specify)	pregnancy	23d. Date of delivery  Month Day	Year		
signed by the	þ	Part II. Other significant conditions contributing to death	but not resulting in the ur	nderlying cause given in Part		bacco use contribute to the cause of 2 No 3 Probably 4			
ficate has been page 2 should	Completed					sy prior to completion of death?			
After this certi funeral director	on: To Be	1 Yes 2 No 1 Inpatient 2 FR/Outpatient 3 DOA 1 Nursing Home 5 Residence 6 Other:							
nours after death neral Director: filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	ury - At home, farm, street	1 Yes 2 N		Street and Number or Rural Route Notate)	umber, City		
within 24 h To the Fun completely	Medical	29a. Certifier 1 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of examiner and manner stated.		on, in my opinion, death occu		and place, and due to the cause(s)	_		
	2	29b. Signature and title of certifier  All Storm And address of person who admitted course of de-	anth /Itam 22cl	29c, License number O.C.M.E.		29d. Date signed (Month, Day, Yea October 31, 2011	ar)		
2+1		30. Name and address of person who completed cause of de Melissa Brassell, MD Assistant Medical  31. Date filed (Month, Day, Year)  32. Registrar		. Baltimore Street, Bal	timore, MD 2122	23			

DHMH 17 Rev 1/2001

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER TODD L ROCKWELL 22,2011 3:10pMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months 218-82-8133 1 ▼M 2 □ F Hours Min. (Month, Day, Ye 48 Director Massachusetts May 1963 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. and I filem 27: is marked other than "natural", or items 23a or 28a-f sho and I filem 27: is marked other than "natural", or items 23a or 28a-f sho ury or orther traumatic event, the Medical Examiner must be notified at ury or orther traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Frederick Emmitsburg Maryland 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11336 Taneytown Pike 21727 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Construction Site Superintendent 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Wallace L. Rockwell Lucille Mollomo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wallace L. Rockwell, father 11336 Taneytown Pike, Emmitsburg, MD 21727 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 10/29/2011 Emmitsburg, MD Emmitsburg Memorial 22. Name and Address of Facility Myers-Durboraw Funeral Home 210 W Main St, Emmitsburg, MD 21727 Signature of Funeral Service Licensee لمير Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ Probable disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). ohysician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death as been signed by the a should be detached Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? page 1 Yes 2 No Yes 2 LIN 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 No မ 1 Inpatient 2 R/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Watural 5 Pending injury within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of D8035267 WIL

State Registrar

6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DK. Manue L 31. Date filed (Month, Day, Year) asiand

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death RÁJABZADEH Physician/ BAHMAN 2 0 1 1 9:25₺ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bel Pre Health & Rehabilitation Silver Spring Montgomery 7. Age (In wrs Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days 1 🕱 M 2 🗆 F Hours 61 1nth, Day Year) 194 Cornto 073 48 3675 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director College Park MdPrince Georges 1 Yes 2 No 10e. Street and Number 5 10g. Citizen of What Country? Funeral 23a 9014 Rhode Island Avenue #702 20740 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces 2 Black, White, etc. ō 1 Never Married 2 Married þ Maryland 21215-0036 Yes Give 1 ☐ Yes 2 🔀 No Specify. Specify: Asian 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Auto Body Repairman Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h ဂ္ Department of Health and Ment. Important: If item 27 is marked any injury or all. Abus Rajabzadeh Anice sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md 20740 19a. Informant's Name/Relationship (Type, Print) Ellie Rajabzadeh. in law #1218 College Pk <u>6200 Westchester Park Dr.</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland National 11/4/2011 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Laurel, Maryland 4 Donation 5 Other (Specify) Signature of Fuperal Service Licensee 22. Name and Address of Facility HALL BROTHERS FUNERAL HOME u 621 Florida Avenue, NW, Wash. DC 20001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). Exam attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death ed by the a 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 🗌 No Yes 2 N 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No ြု 1 L Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation within 24 hours after dear To the Funeral Director., completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9055 ELLICOTTOMY MD 21042 DAVE 0 vaolet State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item I per med cert G921 11/18/11 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death October **Physician** 1012 AM hn Wayne John Wayne Rogers 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Dorchester General Hospital Dorchester Cambridge 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1**∑**M 2□ F Director 216-04-2972 Nov. 21, 1966 Thailand Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d Inside City Limits d other than "natural", or Items 23a or 28a-f show event, the Medical Examinar must be notified at 1 Yes 2 No Director Sussex Seaford DE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 Ross Street United States 19973 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Ves 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 21215-0036 1 ☐ Yes 2 ☐ No Specify: ð Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "nat any injury or other traumatic event the sonce. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State of Delaware 12 Correctional Officer Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walton Wayne Rogers Ranee Hirinvithiya 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Lynn Rogers/Spouse 201 Ross St., PO Box 1098, Seaford, DE 19973 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bangkok, Thailand 4 ☐ Donation 5 ☐ Other (Specify) Thailand Unknown 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Polocus Framptom Funeral Home, P.A. CF5P 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** myocardia disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner Corongra Sequentially list conditions, Examiner day leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician; The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **2** No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical funeral director 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) C1-0006053 10.28.2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FINK 319 N CARTER SMYRNA DE 19977 SOHN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MOA A S SOLL DHMH 17 Rev 1/2001

1561

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #26 per MD FCHD TM 11/3/11 State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician/ 5:45 P. M 2011 John William Seachrist, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Middletown Frederick 2 Keller Lane Date of b... (Month, Day Yea 5. Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 1 M 2 D F 217-42-9339 California 65 Director 1945 Dec. Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If feem 27 is marked other than "natural", or items 23a or 28a-f sho important: If feem 27 is marked other than "natural", or items be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick Middletown tX Ves 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 Keller Lane United States 21769 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 X Never Married 2 Married ģ Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hospital Grant Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Flook John W. Seachrist, Sr. HILDA 19a. Informant's Name/Relationship (Type, Print)
Sharon D. Boyer/Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2 Keller Lane, Middletown, MD 21769 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 30 Geo. Wash. University Medical Center 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 2011 4

✓ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Columbia Mortuary Services, F.A. Signature of Funeral Service Licenses /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line HEPATIC FAILURE Immediate Cause (Final Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ADENOCARCINOMA OF UNKNOWN PRIMARY 4.5 MONTHS Suggestable list acciditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death ed by the a detached f g 🗌 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 🗌 Yes 2 № No 3 □ Probably 4 □ Unknown Completed S"ould 24a. Was an 24b. Were autopsy findings available aw has autopsy prior to completion of cause of death? perform pa 1 ☐ Yes 2 ☐ No Yes 2 To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical Division of Vital To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2,04.00 1 Inpatient 2 ER/Outpatient 3 DOA Horse Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Anatural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 
Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 131761 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SDI W. SEVENTY ST. FREAKPICK Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last)  $P^{M}$ Physician/ 29, 2011 7:25 OCTOBER SUMMERS VERNON Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Airy Mt. Kline Hospice House Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year, 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Days Months 1 X M 2 🗆 F Director Oct. 23, 1953 Yrs 214-48-4609 58 Maryland Usual Residence of Decedent 10d. Inside City Limits show 10c. City, Town or Location 10h County 10a. State the Maryland ä Director 1 X Yes 2 □ No notified 28a-f Frederick Thurmont MD 10f Zin Code 10g. Citizen of What Country? 10e. Street and Numbe ò r items 23a or iner must be r Funeral with 1 U.S.A. 21788 106 East Hammaker Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ 1 Tyes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Aluminum Plant Supervisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ೭ Phyllis Hemp Jonas Vernon Summers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 106 East Hammaker Street, Thurmont, MD 21788 Nancy Summers / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 🛮 🕅 Burial 2 🗆 Cremation 3 🗀 Removal from State 11/03/11 Rocky Ridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Tabor Cemetery 22. Name and Address of Facility Robert E. Dailey & Son Funeral Homes, P.A. Signature of Juneral Service Licensee Frut 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each La Onset and Death Immediate Cause (Final Meningioma Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Brain Meningion Examiner mplica Sequentially list conditions Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury use as the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the at 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has funeral director, page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 \sum Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To this 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Mann of Death 28b. Time of 28c. Injury at After Natural 5 Pending 1 Yes 2 No death. Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

24 hours after death Funeral Director: within 2. To the I

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harpal Singh Mangat, MD 23208 Brewers Tavern Way, Clarksburg, MD 20871

State Registrar 31. Date filed (Moath Day

completely

11-08181 Andrew Smith

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

Cate of Death   Control	andrew Smith		1- For State Registrar	Sta	ite of Marylai			of Dea		a Meni	aı mygı		g. No.	201	1 3701
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23. Part Exceptible despise, or complication/that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart flatture. List only one cause or each low.  23. Part Exceptible despise, or complication/that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart flatture. List only one cause or each low.  24. Exceptible despise, or complication/that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart flatture in the part of the cause of the c	altin mit. P. partme portan	ł				Ga									
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or righty) at a limited events resulting in death). Last    Due to (or as a consequence of):   Due to (or as a consequence of or as a consequence of of consequence of or as a consequence of or as a consequence of or as a consequence			failure, List'on	ly one cause of	n each line.		i, Do not en	ter the mode	e or aying,	, such as ca	ardiac or res	spiratory arre	ist, si 100	k, of fleat	Between Onset and Death
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296. Bignature and title of certifier  296. Dicense number  O.C.M.E.  November 1, 2011  30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State  31. Date filed (Month, May Year) 3 2011  32. Registrar's Signature	8760 ificate	Me.	23b. Was decedent	pregnant in the			,	Fetal death	h 3	Ectopic	pregnancy				•
296. Bignature and title of certifier  296. Dicense number  O.C.M.E.  November 1, 2011  30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State  31. Date filed (Month, May Year) 3 2011  32. Registrar's Signature	ox 61 ath cert attendir	sicia			4 Pregna	nt at time of d									
296. Bignature and title of certifier  296. Dicense number  O.C.M.E.  November 1, 2011  30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State  31. Date filed (Month, May Year) 3 2011  32. Registrar's Signature	D. BC trithe der	F			9 Ulikilok		resulting in t	the underlyin	ng cause	given in Par	rt I.	23e. Did to	bacco us	se contribute to	the cause of death?
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296. Bignature and title of certifier  296. Dicense number  O.C.M.E.  November 1, 2011  30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State  31. Date filed (Month, May Year) 3 2011  32. Registrar's Signature	/ital sician: is certil	å	examiner?		Hospital: 1 In	patient 2	ER/Outpa	tient 3					Residen	ce 6 🗸 Othe	r: Scene
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296. Bignature and title of certifier  296. Dicense number  O.C.M.E.  November 1, 2011  30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State  31. Date filed (Month, May Year) 3 2011  32. Registrar's Signature	Sion Attendi death. ector:	lgi.			igation		<u> </u>				No		_		and Dougla Number City
296. Bignature and title of certifier  296. Dicense number  O.C.M.E.  November 1, 2011  30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State  31. Date filed (Month, May Year) 3 2011  32. Registrar's Signature	Divis				not be			street, factor	ry, oπice i	bullaing, etc	71.55	or Town, St	tate)		
296. Bignature and title of certifier  296. Dicense number  O.C.M.E.  November 1, 2011  30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State  31. Date filed (Month, May Year) 3 2011  32. Registrar's Signature	Hospi 24 hou Funer etely fil												ted.		
O.C.M.E. November 1, 2011  30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State  31. Date filed (Month, May Year) 3 2011 32. Registrar's Signature	To the within To the comple	ledic	one) 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State 31. Date filed (Month, May Year) 3 2011 32. Registrar's Signature		<	255. Digital die allo	(IS)											
State 31. Date filed (Month Cax Year) 32. Registrar's Signature		ŀ	30. Name and add	ress of person	who completed cause	e of death (Iter	n 23a)								
Registrar 31. Date filed (Month NOV 0 3 2011 Server S. Agarks)					122 0		huro -	_		et, Baltim	ore, MD	21223			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 37012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Oct 30 Physician/ Ruth Helen Sing 7:08 A 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6002 Hope Drive Prince George's Temple Hills, If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 M 2 XX Min. Hours (Month, Day, Year, Virginia Director 577 24 3285 88 April 10. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location Directo 1 Yes 2 No Maryland Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6002 Hope Drive 20748 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give XX Black. White, etc. "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced Specify: White Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Restaurant marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Reginald Hubbard Clara Goff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 6002 Hope Drive, Temple Hills, MD 20748 Milton L. Sing (Husband) or other 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or oti 20c. Location - City or Town, State 1 Burial 2 XXCremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Nov 1, 2011 Clinton, MD Lee Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 12 heimer's disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No been signed by the atte should be detached for Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 Yes the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending Division work? 1 Yes 2 No Investigation Accident 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and the of certifie D0052999 allunaer 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10403 Hospital Drive G-06 CLINTON MD 2073> RAHIMIANMD Day, Year 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sewe 9:00 JOSEPH ic 701 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince 5568 Charles rederick Social Security Numbe 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Country) Maizyland 1 X M 2 D F Months Hours Min Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County be filed within 72 hours after death with the Maryland Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 5568 20637 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Yes 2 No 1472 Yes, Give Maryland 21215-0036 1 Yes 2 K No "natural", 3 Widowed 4 X Divorced Black 973 Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) u mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental F ည permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or nethan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20637 Trecercició Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🖍 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) Pregnant at time of death been signed by the should be detached 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? this certificate has autopsy perform 2  $\square$  No Yes 2 No 1 🗌 Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 12 Other: 1 Inpatient 2 ER/Outpatient 3 I 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours To the Funeral L Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 WATHUR 31. Date filed (Month, Day, 32 Registrar's Signature Year) 0 2 201

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 37015 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Catherine Ann Spence October 28. 2011 2:15 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll County Dove House Westminster If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 219-32-8068 1 🗆 M 2 🟋 Director 76 Sep. 17, 1935 Maryland Usual Residence of Decede show 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 28a-f |Maryland Carroll County Manchester 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 21102 United States 4161 Rupp Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Force Black, White, etc. 0. ð 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 72 Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) homemaker own home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) n and Mental I ည Catherine Evans George H. Parsons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Manchester, Maryland 21102 4161 Rupp Road 1 and 2 s of Health item 27 Kenneth J. Spence, Sr./husband Date 2, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Nov. 2011 Manchester, Maryland 4 Donation 5 Other (Specify) Bartholomew Cem. 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licens e Hampstead, Maryland 21074 M01072 934 South Main Street un 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Powvedic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury and -trans that initiated events resulting in death) Last Due to (or as a consequence of): burial-1 as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 - Fetal death in the past 12 months?
1 Yes 2 No for Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown the Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 The law requires Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 2 🗷 No 1 🗌 Yes Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 **Z** No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) HOSPIC E 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completely filled in by the funer (Month, Day, Year) 1 🔼 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiners On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nursel Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the 1 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 101 WJL 5 inpleted cause of death (Item 23a) (Type, Print) Name and address of perso Navana 23 Crossroads Dr OWINGS MILLS, MD 2111 Ste 340 31. Date filed (Month, Day, Year State

Registrar

NOV 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Item 25 per me,g922,12/05/2011dhb
Registrar Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2317 PM avers Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death **Examiner** 4b. City, 4c. County of Death Donchester AMBRIDGE General Hospita Dorchester Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 3-70-8366 1 M 2 F **Director** Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f 1 Ves 2 No 10e. Street and Numbe 10g, Citizen of What Country? Funeral 2161 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) NUVS! ssistant na Be should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည YOV zabet Johnson 19a. Informant's Name/ elationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Freddie Travers Page 1 and 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 MBurial 2 Cremation 3 Removal from State cemetery, crematory or other place Wesley Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Thurch Creek, MD 22. Name and Address of Facility
Henry Funeyal
Sin Luashingt 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final Onset and Death Physician/ PROBABLE ACCELERATED HYPERTENSION disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner BRAIN ANOXIC NJURY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the burial-transi Cause (Disease or finjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 SS IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months? nse 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ for in the past 12 month 1 Yes 2 No Day Year page 2 should be detached 1 ☐ res ∠ ∎ 9 ☐ Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Physician: The law requires HYPERTENSION UNCONTROLLED 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown EDE MA 24b. Were autopsy findings available prior to completion of cause of death? PULMONARY 24a. Was an certificate has performe 2 No Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 279 No Other: Certificate: To 1 X Yes Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending injury 1 Yes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner To the best of my knowledge, death over 29b. Signature and title of certifier 7 D0068045 OCTOBER, 26, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 BYRN STREET, CAMBRIDGE MD 21613 MOHAN DGH. KAVITA 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 0 2 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death Month 11 Physician/ Day 02 2011 Pauline Elizabeth Taylor 4:05 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hartley Hall Pocomoke City Worcester Social Security Number If Under 1 Year If Under 24 Hrs. 8, Date of Birth Birthplace (State or Foreign Country)
VA 6. Sex 7. Age (In vrs. last birthday) Funeral 1 M 2 X F Days 11/970/1922 215-26-5527 88 Director Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Worcester Pocomoke City 1X Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 2119 Orchard Dr. 21851 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 0 þ 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 72 hours after 1 ☐ Yes 2X No Specify: "natural", Specify: White Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Book keeper Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edgar T. Taylor, Sr. Mollie Frances Archer permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Taylor/Sister 2119 Orchard Dr., Pocomoke City, MD, 21851 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) injury or o 1 
Burial 
Cremation 3 
Removal from State Salisbury Crematory 4 Donation 5 Dother (Specify) 11/02/2011 |Salisbury MD 21. Signature of Funeral 22. Name and Address of Facility Holloway Funeral Home 107 Vine St., Pocomoke City, MD, 21851 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ONGESTIVE HEART disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Year Month Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 this certificate 1 Yes 2 No Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Yes 2 No မြ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of s after death, I Director: After to d in by the funera Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 🗌 Yes 2 🗎 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hour To the Fune completed file 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11/2/2011 0 62172

Registrar
DHMH 17 Rev 7/2009

State

SHA2AD

31. Date filed (Month

1604 MARKET ST

POLOMORE CITY MO 21851.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SATYAL: MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 N For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2011 6:20 Рм Michael Jacob Talbott Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Frederick Memorial Hospital Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Apr 9, 1954 **M** 2 □ F Months Days Hours Min 57 Ohio **Director** 216-60-8416 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Knoxville Maryland Frederick 1 Tyes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ian "natural", or items 23a o Medical Examiner must be Funera 2710 West Boss Arnold Road 21758 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene.
27 is marked other than r traumatic event, the Man other than Elementary/Seconday (0-12) College (1-4 or 5+) T.V. Repair Self Employed <u>12</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1. Department of Health and Mental. Important: If item 27 is mortant injury or other" ည Spalding J. Talbott, Jr. Betty Harden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Maple Trail, Fairfield, PA 17320 Rebecca Stinnett, sister 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State crematory or other place) 11/02/2011 Mt. Olivet Cemetery Frederick, MD Donation 5 D Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licenses Myers-Durboraw Funeral Home 210 W Main St, Emmitsburg, MD 21727 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Yes 2 No g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ BSTRUCTIVE LUNG DISEASE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 🗌 No 2 X No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မှ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 2 Accident
3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) License number WIL 1013012011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 32. Registrar's Signature State

Registrar

NOV 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 4 Physician/ October 21, 2011 Year 10:29 AM Shirley Lee Williams 9 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8 Shady Grove Adventist Hospital Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 21/2011 1 🗆 M 2 🔀 F Hours July 10, 1950 214-48-9840 Director 61 Maryland Usual Residence of Decedent show 10a. State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10b. County death with the Maryland 10c. City. Town or Location Director 10d. Inside City Limits Maryland Montgomery 1 Yes 2 X No Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19707 Crystal Rock Drive, Apt. 11 20874 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. Completed by 1 Never Married 2 Married should be filed within 72 hours after 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. White 3 Widowed 4 N Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than ' Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) 11 School Bus Attendant Public Schools Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Robert Griffith Doris Irene Grimes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy Griffith / Daughter 15015 Hyattstown Mill Rd., Clarksburg, MD 20871 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 0ct. 2<u>011</u> permit. Page 1 Department of Important: If it any injury or o cemeter, crematory or other place)
Resthaven
Memorial Gardens 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 21. Signature eral Service Licensee Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 23a. Part 1. Enter the disease e or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Approximate Interval Between Onset and Death shock, or beart failure. Immediate Cause (Final disease or condition resulting in death) Physician/ Failure Spiratory Medical Examiner Aspiration Pneumonia Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury Due to to Myocardial Infarction Hospital or Attending Physician: The law requires that the death certificate be executed うて the attending physician and hed for use as the burial-trans that initiated events resulting in death) Last 'entricular Fibrillation Arrest Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month 1 Yes 2 s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes 1 Yes 2 No 3 Probably 4 Unknown Fibrillation 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has t autopsy cholecysticis perform death? After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 \sum Yes 2 \times No director, Be ( 26. Place of Death (Check only one) Hospital ပ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' Accident Investigation 1 Yes 2 🗌 No Suicide
Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours aft

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurr only one) ed at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu re and title of certifier 29d. Date signed (Month, Day, Year) 21 0 117 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 9901 Rockville Mits Dr Dana Medical 20850 State Registrar's Signatu 03 2011 recent Registrar

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eginald Jerom			ent of Health and Mental H ate of Death	ygiene Reg. No.	2011 3702				
Physici Medical Exami		Decedent's Name (First, Middle,Last)     REGINALD JEROME WILLIAM     4a. Facility Name (if not institution, give street and number)     1028 Windmill Lane	4b. City, Town, or Location of Death Silver Spring	N	. County of Death Montgomery				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bird UNKNOWN	thday) If Under 1 Year If Under 24Hrs  Months Days Hours Min	s. 8. Date of Birth (MM// EPT 17 19	DD/YYYY 9. Birthplace (State or Foreign WASH • Country)				
uyland Sa-f show any af once.	tor	MD 10b. County 10c. City, Town SII	VER SPRING	Lang Citi	10d. Inside City Limits 1 \( \subseteq \text{Yes} 2 \subseteq \text{No} \) zen of Whet Country?				
ith the Maryland 23a or 28a-f sho notified at once	al Director	10e. Street and Number  1028 WINDMILL LANE  11. Marital Status  12. Was Decedent Ever in U.S.	10f. Zip Code 20905  13. Was Decedent of Hispanic Origin? ( S)		USA  14. Race - American Indian, Black,				
after death wi	by Funeral	1 Never Married 2 Married Armed Forces?  1 Yes 2 No  3 Widowed 4 Divorced If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc. Specify: BLACK				
Imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items 23a or 28a-fah or other traumatic event, the Medical Examiner must be notified at once	Completed I		Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use reting LABORER	ired)	CIVATE				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	BB	17. Father's Name (First, Middle, Last) ROBERT P. WILLIAMS SR.	LYDIA						
MD 2' nd 2 should alth and M m 27 is ma	7	ROBERT P. WILLIAMS JR 2	b. Mailing Address (Street and Number or 2024 JACKSON ST.N of Disposition (Name of cemetery,	E WASH. D					
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		1 Burial 2 Cremation 3 Removal from State RIVERDALE PARK 4 Donation 5 Other Specify: CREMATORY  21. St Inature of Funeral Service Licens 22. Name and Address of Facility							
Physician	_	23a. Part I. Enter the disease, or complications that caused the death. Do no	WATSON FH 3435						
/Medical xaminer		failure. List only one cause on each line.	eatic Adenocarcinoma		Between Onset and Death				
,	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause c.							
cecuted 1 and - transit	al Examiner	events resulting in death) Last  Due to (or as a consequence of):  d.							
ox 68760, rath certificate be ex attending physician or use as the burial	/Medic	IF FEMALE: 23c. If yes, outcome of pregnancy	me,g923 1-12-12 sm		d. Date of delivery				
Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Medic	past 12 months?  1 Yes 2 No 9 Unknown  Unknown	Petal death 3 Ectopic pregnic Specify)		Month Day Year				
<b>s, P.O. E</b> uires that the c n signed by the	Š	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.	1  Yes 2 ₩	use contribute to the cause of death?  No 3 Probably 4 Unknown  1 24b. Were autopsy findings available				
of Vital Records, P.O.  g Physician: The law requires that the there is that the certificate has been signed by neral director, page 2 should be detach	Completed			24a. Was an autopsy performed?	prior to completion of cause of death?				
n of Vital Recing Physician: The After this certificate funeral director, page	n: To Be	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b.	Time of Injury 28c. Injury at Work?		ence 6 🗹 Other: Scene				
the sath	Certification:	2 Accident Investigation	1 Yes 2 No	28f. Location (Street a or Town, State)	and Number or Rural Route Number, City				
Divisi To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one)  2  Medical Examiner: On the basis of examination and/or in and manner stated.							
F 3 F 3	Me	29b. Signature and title of certifier	29c. License number O.C.M.E.		Date signed (Month, Day, Year) vember 7, 2011				
R			900 W. Baltimore Street, Baltin	more, MD 21223					
Si Regis	ate	31. Date filed (Month, Days) 32. Registrar's lignatur	Res						

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October We1ch Lawrence 26,2011 1530 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year)
ct 24,1944 Days Hours Washington DC 1 🔀 M 2 🗆 F 67 Director 0ct 579<u>-58-8302</u> Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director XX Yes 2 No District of Columbia Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 2319 Hartford Street SE 20020 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Custodian Twelfth None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Hattie C. Welch Lawrence Osbourne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9430 Wilcoxen Dr., Manassas Park, VA 20111 19a. Informant's Name/Relationship (Type, Print) Maxine V. Coleman/Girlfriend Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November Page 1 permit. Page 1
Department of I
Important: If it
any injury or o ō 1 🗷 Burial 2 🗌 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Lincoln Cemetery 11,2011 Suitland Maryland 22. Name and Address of Facility Robert G Mason Funeral Home Inc Signature of Funeral Service Lice Donald R Gray 1661 Good Hope Rd SE Washington DC 20020 23a. Part 1. Enter the disease, or compli Approximate Interval Between Onset and Death s that caused th ot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on se on each line. Immediate Cause (Final Enysiciani disease or condition Medical resulting in death) Due to (or as a consequence of): €xaminer Sequentially list conditions, if any, caching to include cause. Enter Underlying Cause (Oisease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to for #s a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this contract. ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav Year Pregnant at time of death 5 Other (specify) Month 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Únknown 24b. Were autopsy findings-available prior to completion of cause of death? 24a. Was an autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2X No Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X** No 1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined Medical 1 \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 \*\*Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie M.0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) silver syring, 2101

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11/05/2011 Year **Physician** LILLIAN K. ABRAMSON  $P^M$ 7:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Somerford House Frederick 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 1 M 2 F Hours 103-05-3478 93 05/05/1918 Director New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show e or 28a-f sh Director MD 1 □Yes 2 □ No Frederick Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6220 Glen Valley Terrace #G 21701 USA ed other than "natural", or items 23e event, the Medical Examinar must be Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2 X No Specify: 2 Specify: 3 → Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "n. any injury or other treumatic event. The Manage. Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Kaplan Anna Eleanor Lipkin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Musinski (Daughter) 6220 Glen Valley Terrace #C/Frederick MD 21701 altimore. 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metropolitan Crematory Alexandria VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Advent Funeral & Cremation Services Falls Church Va and Annapolis MD > Mest Wi Malicu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Intluduzae /Medical Due to (or as a consequence of): Examiner Parkin son Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown s peen s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy this certificate of Vital 2XINo 2 **X** No 1 □Yes 1 ☐ Yes Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 45555 1 Yes 2 No ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral ours after death.

nerel Director: After the filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Natural
2 Accident Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

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D 51643

Thomas Thonson & Frederick 21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First Middle, Last) 2. Date of Death Physician/ Month Brown 10.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** enter N/A Baltimore 11/100 Social Security Number 7. Age (In vrs. last birthday) If Under 1 If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex Year 8. Date of Birth Funeral (Month, Day, Year Country)
Maryland 1**X** M 2 □ F Days Hours 216-36-0466 **Director** 71 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified <u>at</u> permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 USA 601 Wyanoke Avenue Apt. 421 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married XYes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2XXVo Specify: Specify: Black Completed 3 Widowed 4XXDivorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) U.S. Postal Elementary/Seconday (0-12) College (1-4 or 5+) Carrier Service 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Evelyn Charlotte Miller William Noble Brown, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5031 Truesdale Avenue Baltimore, MD 21206 Gregory Brown/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/17/11 Baltimore, MD Greenmount Cem. 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licenses Belair Road Baltimore, MD 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. letastat Unknown Immediate Cause (Final an Ger Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached. Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death 2 No 9 Unknown g 🖂 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 M No 1 Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ense number THE MID iss of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	partment of Health and Men ertificate of Death	•	2011	37024					
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last)  Samuel Nathaniel Brown, III.  4a. Facility Name (If not institution, give street and number)  Futurecare Homewood		ov. 9,	Day Year 2011  4c. County of Death N/	3. Time of Death 11:30A <sup>M</sup>					
	Funeral Director		218-74-3377 1XM 2□F 53 Yrs.	ocial Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth								
deeth with the Maryland ms 23a or 28e-f ehow rmust be notified at	Marylend e-f ehow	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I  MD N/A	Docation Baltimore		1	10d. Inside City Limits 1 XYes 2 ☐ No					
	h with the	al Director	10e. Street and Number 3405 Harford Road	10f. Zip Code 21218	10g. (	Citizen of What Coul USA	nt <b>ry</b> ?					
030	urs after deel al', or Items : Examinar mu	by Funeral	11. Marital Status  1 □ Never Married 2 Married  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ X'es 2 □ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	Yes or No- n, etc.)	14. Race - Americ Black, White, Specify: Bla	etc.					
ife, Maryland ZIZID-UU30 s 1 and 2 should be filed within 72 hours after deeth with the Marylen f Heelin and Mental hygiene. f the file marked other then "natural", or items 23a or 28e-1 show other traumatic event, I' a Mudical Examinar must be notified at	d within 72 ho plane. Ir then "natur Ir a Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 1 year  16a. Dec (Giv ife.	S		Maryland Human Res						
	uld be file Mentel Hyg irked othe	To Be C	17. Father's Name (First, Middle, Last) Samuel N. Brown, Jr.	18. Mother's Name (Fir Marlene		en Sumame)						
	ond 2 sho eith end 1 27 is ma er trauma			ling Address (Street and Number or Rural Ro 5 Harford Road Ba								
saitimore,	permit. Pages 1 e Dapartment of He importent; if item eny injury or othe		'4 □Donation 5 □Other (Specify) Garris	ossition (Name of ematory or other place) 11/18/Pate on Forest Vet. Ce	m. O	Location - City or To wings Mi	lls, MD					
Dail	Daparti Daparti Importi eny Inj		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Chat 4210 Belair Road								
You, A	Physician /Medical Examiner the primal-transit	dicai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not expock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	Selvers			Interval Between Onset and Death					
O. DOX 0	ires that the daath certificate tsigned by the attanding physid be detached for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5 9 □ Unknown		23d. Date of delivery Month Day Year							
olds, r	quires that the signed by a signed by a detact	by	Part II. Other significant conditions contributing to death but not resulting in the		ise contribute to the cause of death?							
ng Physician: The law fiter this certificate has b	: The law rec cate has bee page 2 shot	Completed			24a. Was an autopsy performed' 1 🗆 Yes 2 🖼	prior to co death?	opsy findings available impletion of cause of					
	or Attending Physician after death, Director: After this certifi in by the funeral director	Certification; To Be	25. Was case referred to medical examiner?  1 Yes 2 No									
5	To the Hospitel or Attendi within 24 hours efter death. To the Funerel Director: A completely filled in by the fu		4 Homicide building, efc. (Specify)  City or Town, State)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	To the Ho	Medical	(Check only one)  2 Madical Examiner: On the basis of examination and/or i and manner stated.  29b. Signature and title of certifier	nvestigation, in my opinion, death occurred at 29c. License number	t the time, date a	and place, and due to Date signed (Month,	o the cause(s)					
)	\		30. Name and address of person who completed cause of death (Item 23a) (Type	D 31464		11/9/11						
B	Sta		SHOAIS A. HAS DANI MD S21 N.  31. DaNOVA211 D20Year)  Security S. Signature	EUTAW ST Smite	308 3	ALTIMOI	20 21201					
	Registr	ar	p. gare									

23d. Date of delivery Dav 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Hinknown 24b. Were autopsy findings available prior to completion of cause of death? 2 14 2 1 NO 1 Yes 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Malealm drive Westmirter

 $P^{M}$ 

6:22

9. Birthplace (State or Foreign

10d. Inside City Limits

Interval Between

Onset and Death

1 🗌 Yes 2 🖳 No

Maryland

Carroll

14. Race - American Indian

White

Black, White, etc.

Registrar DHMH 17 Rev 7/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. RAMAN B. KANEUR, 349 Mali

32.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month John Robert Bland November 2011 11:25 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 155 South Grundy Street Apt 207 Baltimore Social Security Number . Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 XM 2 □ F Months Days Hours Min 11718/1940 North Carolina Director 212-40-1715 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location death with the Maryland notified at 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Baltimore 10f. Zip Code ö 10e Street and Number 10g. Citizen of What Country? the Medical Examiner must be 23a Funeral 155 South Grundy Street S. items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò þ 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 hours after 1963 1965 1 ☐ Yes 2 🕅 No Specify: "natural", Specify: Completed 3 Divorced 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Disabled Disabled Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event any injury or other traumatic event often. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, ဂ္ Edgar McCoy Bland Nellie Marie Mizelle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nellie Marie Bray (Mother) Essex, Maryland 21221 2 Clipper Road 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 11/23 2011 1 🐰 Burial 2 □ Cremation 3 □ Removal from State Middle River, Maryland 4 Donation 5 Other (Specify) Mem. Gard 21 Sign Ture of Fundamentics Lice 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Es<u>sex, Maryland 21221</u> Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ arrhythmia Cardiac disease or condition resulting in death) mmediate Medical Examiner months atherosclerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to for militiar more permanents of the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) \_\_\_\_ in the past 12 months? Day Pregnant at time of death s been signed by the s should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 🔀 Yes 2 □ No 3 □ Probably 4 □ Unknown pertension Completed 24b. Were autopsy findings available prior to completion of cause of death? nyperlipidema 24a Was an autopsy performed? Yes 2 X No this certificate has page 1 Yes 2 No rector, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: \_2 🗆 No 1 X Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) in 24 hours after deau...
The Funeral Director: After the Funeral Director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 XNatural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 3 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29h. Signature and title of certifie 003536

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Mo

HILL

BUAMO

MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bankard, Maryanna

			Please	Type or						-		_	e.
		For State		State of	Marylan					Mental F	lygien	ie	1 0700
		Registrar  1. Decedent's Name (	First Middle La:	st)	_	Cer	tificate o	т реа	เเก	2. Date of	Reg. I	4o. 2 []	3. Time of Death
Physic Med		Maryanna		Bankaro						Month		P 20	or A 1/A
Exami	ner	4a. Facility Name (if no			,	i	0		ation of Death			c. County of D	
Funera		5. Social Security Num	1/1 0940 ber 6. S		7. Åge (In yrs. I		KoS(	ear If L	Jnder 24 Hrs.	8. Date of		Balti	Birthplace (State or Foreign
Directo		219-38-919	3 1	□ M 2 <b>X</b> ] F		Yrs.	Months D	ays Ho	ours Min.	(Month,	Day, Year	)	Country)
nd at	٦	Usual Residence of I	Decedent 0b. County		70	y, Town or Lo	cation			1 7/22	/194	1	Maryland 10d. Inside City Limits
he Maryland or 28a-f show notified at	ecto		Baltimo	<b>r</b> 0	Esse								1 Yes 2 XNo
the Man or 28	Funeral Director	10e. Street and Number		LE	Libba	<u> </u>	10f. Zip Co	de			10g. (	Citizen of What	Country?
h with ns 23; must l	nera	612 Maryla	nd Aveni	ue			2122	21			U	S. A.	
036 s after death with ral", or items 23 Examiner must		11. Marital Status  1  Never Married	1 2 Married	12. Was Deced	ces?		Vas Decedent f Yes, specify (	of Hispan Cuban, Me	ic Origin? (Sp exican, Puerto	ecify Yes or N Rican, etc.)	10-		merican Indian, /hite, etc.
O36 's afte	q pa	3 Widowed 4		1 ∐ Yes If Yes, Give Year or Dat		1	☐ Yes 2 🔀	No Sp	ecify:			Specify:	hite
21215-0036 within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho, the Me Toal Examiner must be notified at	Completed by		15. Decedent's E y only highest gr			16a. Deced	lent's Usual O	ccupation	most of wor	dina	16b.	Kind of Busine	
121 Ithin 7 ene. than	l l	Elementary/Second		College (1-	4 or 5+)		kind of work do O NOT use ret			9	B	altimor	e_City
nd 2	Be	17. Father's Name (First	st, Middle, Last)			OTTI	ce Mana		Mother's Nan	ne (First, Midd			#1C
ylar d be f Menta arked	은	Lawrence	Martin	Dotterw	eich, s	Sr.		M	ildred	Mari	e Gi	riffin	
Maryland 21215-00 42 should be filed within 72 hours alth and Mental Hygiene. 27 is marked other than "natura is traumatic event, the Merical E.	L	19a. Informant's Name	e/Relationship (7	ype, Print) (Br	other)	19b. Mailir	ng Address (St	reet and N	lumber or Rui	al Route Nun	ber, City	or Town, State,	Zip Code)
re, M 1 and 2 s of Health item 27 other tra	П	Roland Jam 20a. Method of Dispos	es Dotte				5 Mace sition (Name o		ue Es	sex, M		and 212	21 or Town, State
Baltimore, N permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 once.	П	1 🗆 Burial 2 🗀	Cremation 3	Removal from S	State C	emetery, cren	natory or other	place)	_   ,	11/22 2011		-	
altir mit. P partm partm portar / injur		4 ☐ Donation 5.  21. Signature of Funer			ment M	22	. Name and A	ddress of I	Facility	3.5			, Maryland
a Ferrina		Much	ul C	Jak	has.	50 I	Bruzdzi 1407 ol	nski d Ea:	Funer stern	al Hom Avenue	e PA Ess	sex. Ma	ryland 21221
Physician		23a. Part 1. Enter the shock, or heart for Immediate Cause (Fin disease or condition		plications the earline cause on each		h. Do not ente hoしん	er the mode of	dying, suc	ch as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
Medica Examine		resulting in death)		Due to (o	r as a consequ	sche	mil						
+	Examiner	Sequentially list cond if _n_, e_dingimm cause. Enter Underlyi Cause (Disease or inju	itions,	b. Due to to	r as a consequ	ience of):							
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7760 ficate g phys	Medi			d. <u>COTT</u>	Pirco	7.77	9 . 47	700	<u> </u>	<u></u>	<u> </u>	909	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the total process.	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pre in the past 12 mg 1 ☐ Yes 2 ☐ 1 9 ☐ Unknown	egnant pths? No		irth 2 🗌 Feta ant at time of c	al death 3	Ectopic preg Other (specif				_	23d. Date of Month	delivery Day Year
P.O.	by Pt	Part II. Other significa	ent conditions o	ontributing to dea	ath but not res	ulting in the u	nderlying caus	e given in	Part I.				e to the cause of death?
dS,	ted									1	Yes		Probably 4 Unknown
law re	mple									24a. W au	as an utopsy erformed?	24b. Were prior death	autopsy findings available to completion of cause of
R: The ficate or, pag	ပ္သ	25. Was case referred	to medical					0. Di	(D # /0/	1 🗆 Ye	es 2	No 1 🗆	Yes 2 No
Vita ysicial s certi	To Be	examiner?	111	Hospital:	patient 2 -	ER/Outpatien		Other:	Death (Chec		peidonco	6 Other (S	nacih/l
of \ ng Phy ter this		27. Manner of Death	5 Pending	28a. Date of		28b. Time of injury	28c. I	Injury at work?	□ Nursing n			ury occurred	Jeculy)
ion tendir death. tor: Af	ifica	2 Accident	Investigation  Could not b	1			M	1 🗌 Yes	2 🗆 No				
Division of Vital Records, rat or Attending Physician: The law requires s after death.  I Director: After this certificate has been signed in by the funeral director; page 2 should be a should by the funeral director.	Cerl	4 🗆 Homicide	determined	28e. Place o building	of Injury - At ho g, etc. (Specify	me, farm, stre	et, factory, off	ice			n (Street a Town, Sta		Rural Route Number,
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach	Medical Certificate:	(Check 2 L	Medical Exam	sician: To the bei	of examination	n and/or invest	igation, in my o	pinion, de	ath occurred a	t the time, dat	te and plac	ce, and due to t	he cause(s) and manner state
o the vithin 2 o the comple	ž	only one) 3		se Practitioner:	To the best of n	ny knowledge,		at the time		ace, and due	1		er as stated. onth, Day, Year)
<b>A</b>		12 m	mul.	Shun	ner	MD	100	005	536	94	1	1/19	111
101		30. Name and address	of person who	completed cause	of death (Item	23a) (Type, P	or line	Sau	are	Daire	e R	altimo	re, MD2P3
Sta Regist		31. Date filed (Month,	ody, Year) V 2 1 20	32	gistrar's Signat	1 ha	we	7		- I V.			
		INC	11 ST T	111/4014	M								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 15\_2011 Physician/ NOVEMBER BARBOUR 2:36 P MARCELLINE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Year) Director 1 🗆 M 2 💢 F 73 224-58-6813 FEB. 7 1938 Usual Residence of Decedent VIRGINIA "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD PRINCE GEORGE'S HYATTSVILLE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1404 CHILLUM ROAD 20782 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: BLACK 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11th permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the CHILDCARE PROVIDER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ WILLIE MACK BROWN JANET WINSTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1404 CHILLUM ROAD HYATTSVILLE, MARYLAND 20782 ROBERT BARBOUR/HUSBAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 11/28/11 CLINTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) tinana Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami requires that the death certificate be executed and I-tran that initiated events physician ar s the burial-t resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending ph IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year been signed by the should be detached Unknown 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ betes Mellitul Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4🍂 Unknown Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an aw has page 2 Obstructive fulminaly Disease perform Chronic 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital: 1 Tes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after usus...

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of certific

31. Date fil

Koma

ress of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

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DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene state of Mental Hygiene certificate of Death

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11:55 AM Broussard 2011 November Dorothy Mary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Montgomery Suburban Hospital . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. February 22, 1934 Country Louisiana **Director** 434-46-9560 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Gaithersburg Montgomery Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20878 United States 397-101 West Side Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Meone, and injury or other traumatic event, the Meone and injury or other traumatic events. Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Computer Technician IBM Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Henry Mayfield Alice Casborn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 397-101 West Side Drive, Gaithersburg, Maryland 20878 Meloney Maria Jones/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State Date November 10, 1 Durial 2 X Cremation 3 Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 Signature of Funeral Service Licensee Robert and Ad Pringhtaey Funeral Home/Bethesda-Chevy Chase, Inc. topas) Tanne 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Lutracecentral PULLVIM Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of EXAMINER been signed by the attending physician and should be detached for use as the burial-transit executed CERTIFICATION APPROVED BY MEDI that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Box in the past 12 months?
1 Yes 2 X No Dav 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has performed? Yes 2 No death? this certificate 1 ☐ Yes 2 ☐ No **Division of Vital** Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 XYes Other: ည 1/2 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 5 Pending 1 Natural 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month, Day, Year) ress of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

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Dorothy

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Atol Rohatgi, M.D. 8600 Old Georgetown Road, Bethesda, Maryland 20814

22. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Item 25 per me,g921,11/18/2011dhb
Registrar
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Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Bucci Theresa Month Day Year Physician/ 10 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Boiltimore Rosedale Franklin Square Hospita Center . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 212-30-4323 Hours Min 100/12 1 / 1 934 MD Director 1 □ M 2 □XF 10a. State MD or 28a-f show 10d. Inside City Limits 72 hours after death with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location **Funeral Director** Baltimore 1 X Yes 2 No 100. Street and Number Grove Manor Drive, Apt 10f. Zip Code 10g. Citizen of What Country? 21221 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status þ 1 Never Married 2 Married ☐ Yes 2 🗶 No Baltimore, Maryland 21215-0036 Specify:White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Completed 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) filed within College (1-4 or 5+) Service Waitress To Be 17. Father's Name (First, Middle, Last)
Stephen George 18. Mother's Name (First, Middle, Maiden Catherine Surname) Barry pe 1 Page 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 657 Hunting Fields Road, Baltimore, 19a. Informant's Name/Relationship (Type, Print) MD 21220 Department of Health a Important: If item 27 is any injury or other trains Hunting Fields Road, Carlo Bucci Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date AtTantTc the material ory 10/27/20 1 Burial 2 X Cremation 3 Removal from State Glen Burnie, 4 ☐ Donation 5 ☐ Other (Specify) Marshall 22. Name and Address of Facility

Pary box 1463, Baitin Servines 21203 Dorota 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Respiratory Due to (1 as a consequence of): Distres disease or condition Medical resulting in death) Examiner Follicular Thyroid Concer Gagueritary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Subsequent Acidosis attending physician and afor use as the burial-transit Injury ATION ANAPOROUGH BY MEDICAL EXAMINER Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis. IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Division of Vital Records, P.O. Box in the past 12 months?
1 ☐ Yes 2 🗷 No Year Pregnant at time of death Month Day signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' 1 Yes 2 X No Yes 2 X No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🔾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 10/25 (1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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62. Registrar's Signature

Bucci

9000 Franklin Square Drive, Baltimore MD.

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) November 16, 2011 12:04 PMM Marlene Burns 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) N/A Baltimore Good Samaritan Hospital 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 11/107-/1943 Hours Mary Land 66 212-46-4078 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 🖔 No Hillendale Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21234 1801 Wentworth Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces 1 Never Married 2 Married Yes 2 No White 1 ☐ Yes 2 X No Specify: If Yes. Give 3 Widowed 4 Divorced Year or Dates. 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sophia Elizabeth Dziadziucka John Whitener 21P gailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) <del>109</del> Cameron Drive Dundalk, Maryland 21222 Apt 1A Tammy Burns / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 🗀 Burial 2 Cremation 3 🗔 Removal from State Glen Burnie, Maryland 11/18/2011 4 Donation 5 Other (Specify) Signatu of Funeral Service 22. Name and Address of Facility David J. Weber Funeral Homes PA 401 S. Chester Street Baltimore, Maryland 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 010 disease or condition Due to (or as a consequence of) rah Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery Ectopic pregnancy Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe Yes 2 death? 1 Yes 2 No 1 Yes 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 ☐ DOA 28c. Injury at work? 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 5 Pending Natural

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit P.O. Box 68760 Division of Vital Records,

Physician/

Medical

**Examiner** 

**Funeral** 

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of Health and Mental Hygiene.
item 27 is marked other than "natur other traumatic event, the Medical

Department of Health ar Important: If item 27 is any injury or other trau once.

Physician/

Medical resulting in death) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregna in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 25. Was case referred to medical Certificate: To Be examiner? 1 🗌 Yes 27. Manner ath 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number City or Town, State) determined Medical Certifying Physician. To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number November 16,2011 40059540

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year Physician MYIC Brown 01:26 AM 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Mercy Medical Cente
5. Social Security Number 6. Sex 7. A Baltimore
If Under 1 Year | If Under 24 Hrs. City Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Hours 1 □ M 2 🔀 F Months Year) Days Yrs. Director 10 18 2011 maryland Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 XYes 2 □ No Funeral Director MO 10g, Citizen of What Country? 10e, Street and Number 10f. Zip Code ö USA 1341 21218 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
int: If item 27 is marked other than "natural", or Items 23 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo ģ If Yes, Give Year or Dates: Specify Black 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) NIA NIA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ Shanetta UNKNOWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brown Baltimore Shanetta mother 1341 Gorsuch 21218 mp 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedra 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Se Bradley 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. d. 21232 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Non-Viable pregnanchu /Medical Due to (or as a consequence of): **Examiner** Chorioamnionita Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Premature Eupture of Membranes the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 XNo 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident ours after death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink, Fasure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 37034 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 16 THOMAS Ε. BUCK 7:15 P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Stella Maris Hospice Timonium Baltimore 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Date of Birth **Funeral** Min (Month, Day, Year) Months Hours Director 284-34-2220 71 1X M 2 | F Vrc 06/25/1940 Ohio Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f s Norfolk VA Norfolk 1 Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Completed by Funeral 23a 6030 Newport Avenue 23505 U.S.A. ral", or items 2 Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black. White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", 3 ₩ Widowed 4 Divorced Year or Dates. 1962-1994 White Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Brigadier General United States Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) November 16 ဂ္ဂ Agnes James Buck Sandburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6404 Steel Flower Path Wendy E. Holland / Daughter Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 Post Cemetery (Cemetery) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/22/2011 West Point, NY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The Johnson Funeral Home, P.A. MOO217 8521 Loch Raven Blvd., Towson, MD 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ UNG disease or condition resulting in death) Medical (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) as the burial-transit Cause (Disease or injury the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ signed by the atter in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 1 Yes 2 No Probably 4 Unknown sompletely filled in by the funeral director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural Accident injury 5 Pending Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title 29d. Date signed (Month, Day, Year) 2011 cause of death (Item 23a) (Type, Print) 30. Name and add 2300 Dul THONIUM State Registrar

HOMAS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 18, 2011 MILTON ANDREW CITRANO 3:00 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Johns Hopkins Bayview Care Baltimore Baltimore Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) 1 X M 2 🗆 F Months Hours (Month, Day, Year) Director 457-52-7709 80 1931 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at Funeral Director 10d. Inside City Limits MD Carroll Sykesville 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 5240 Freter Road 21784 **USA** 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces 1 Yes 2 No 1952 Black, White, etc. ö þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 "natural", 1 ☐ Yes 2 ☐ No Specify. Completed 3 Divorced Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Social Security Admin. claims clerk traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Samuel Citrano Josephine Mancuso 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health tem 27 Mrs. Barbara Citrano/ spouse 5240 Freter Rd., Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-21-11 Sykesville, MD All County Cremation 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Parge Haight Sterbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death -Physician/ Arrhythmia disease or condition Medical resulting in death) Examiner months DIVATORY tailure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant Box 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 4 Pregnant a Pregnant at time of death Month 1 Yes 2 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Neuroendocrine tumor Records, cate has been signated by page 2 should b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 1 Yes 2 No Yes 25. Was case referred to medical examiner? of Vital æ 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 No ဂ္ 1 

Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending Division hours after death. Ineral Director: Aft d filled in by the fur 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗆 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral Completed filled in the completed filled filled in the completed filled fi Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and from the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) November 18, 2011 145757 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Maryland 21224 McNabney 5505 Hopkins Bayview Circle 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 20 37036 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Barbara Jane Colson November 20, 2011 11:41 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carrol1 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Days 214-34-4047 **Director** 1 🗆 M 2 😾 F 74 Sept 23, 1937 MD Usual Residence of Deceden 28a-f show aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 ☐ Yes 2 🄀 No MD Howard Woodbine 0 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 21797 United States Woodbine Morgan Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. White r than "natural", the Medical Exa Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry should be filed within 72. and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Nursing Rosewood Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tra Melvin Harrison Mildred Irene Brightwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 17360 Frederick Rd. Mt. Airy, MD 21771 Victoria Boone (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō permit. Page 1 Department of Important; If ii any injury or or XXBurial 2 Cremation 3 Removal from State Morgan Chapel Cem 11/23/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burrier-Queen Funeral Home and Crematory, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Myocardia disease or condition resulting in death) Medical or as a consequence of Examiner pertension Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury as a consequence of Due to (o Examin Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last burial physician s the burial sidemin Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ į in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown the 9 Unknown signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Jas autopsy performed? Yes 2 certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: ျ 1 Inpatient 2 FR/Outpatient 3 IDOA this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Hospital or Attending (Month, Day, Year) 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident after death

Director: A
d in by the f Investigation М 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) completely filled 24 hours a Medical 29a. Certifier 1 🏿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) Signature and title of certifier Ships 290 License number 663 29d. Date signed (Month, Day, Year) 11-21-11

lame and address of person who completed cause of death (Item 23a) (Type, Print) Ridge Rd, Weshingster Md. 21157 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year

State of Maryland / Department of Health and Mental Hygiene 37037 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER Day 15 2011 JOHN CAISON 5:08 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6602 OAK STREET CHEVERLY PRINCE GEORGE'S Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** oct 16 1 X M 2 🗆 F Months Days Hours Min VIRGINIA 226-36-4211 83 "I928 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 XYes 2 No MD PRINCE GEORGE'S CHEVERLY 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 6602 OAK STREET 20785 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. ö þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 BLACK If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: "natural", Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5th PRIVATE MANAGER permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ NIMROD CAISON GERTRUDE RAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUANITA CAISON/DGT. 6602 OAK STREET CHEVERLY, MARYLAND 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/19/2011 RIVERDALE, MARYLAND RIVERDALE CREMATORY 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ GASTRIC CARCINOMA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury signed by the attending physician and a betached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day 5 Other (specify) Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 🖾 No Other: 1 Tes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 🗌 Yes 2 🔲 No Accident Investigation Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 24 hours Funeral 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year) Hard NOVEMBER 17, 2011 D37391 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7404 EXECUTIVE PLACE #502 LANHAM, MARYLAND 20706 ROCHELLE S. HARDY M.D.

W DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Yea

NOV 2 1 2011

32. Registrar's

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Y M 16.21 chert Novemb 2011 18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore rew Medical the plans Cente 5. Social Security Number 2/9-22 -50 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrş. last birthday) 84 Days Min 1 M 2 □ F Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show event, the Medical Examiner coust be notified at 1 ☑Yes 2 ☐ No Director 28a-f s MD 10g. Citizen of What Country? 10e. Street and Number 9 items 23a 21222 by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates: WW ] / [ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau 21232 Dundalk 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility radle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cardiogenic **Physician** /Medical Due to (or as a consequence of): **Examiner** ocardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 687605 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.0. been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has be rector, page 2 sl autopsy 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 patient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined 4 ☐ Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

MD

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Nov. Physician/ Day 18 2011 9:15 A M Charles Lee Callahan Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Howard Columbia Home Assisted Living Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Min. (Month, Day, 1 ▼ M 2 □ F 83 **Director** 233-38-9488 1928 Nov Usual Residence of Decedent or 28a-f show 10a. State 10b. County filed within 72 hours after death with the Maryland ural", or items 23a or 28a-f sho I Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Anne Arundel 1 🗌 Yes 2 🙀 No Hanover Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21076 23 Leeds Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: White "natural". Specify. 3 Widowed 4 Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Scott Della Howard Callahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leeds Road, Hanover, Maryland 21076 Betty M. Callahan - Wife 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🔲 Burial , 2 🏋 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 11/20/2011 Glen Burnie, MD 21. Sign stury Funeral Service 22. Name and Address of Facility Gary L. Kaufman F.H. @ MMP 250 Washington Blvd., Elkridge, Maryland 21075 r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Part 1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Fina Liver Carcinoma Onset and Death Metartatic robable Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a co Cardiovascular Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months?
1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has autopsy certificate 2 No 2 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes 2 No Group ho my ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this Within 24 hours after deau..

To the Funeral Director. After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Accident Suici-' 1 Natural 5 Pending work? 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined cal 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 20 2011 1) 30641 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ramech Sabapathi 201-109 Back River Mcck Road Balhmer Mayland 21221

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37040 State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Shirley Dorsey 7:40 PM November 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Randallstown Baltimore Seasons Hospice at Northwest Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days (Month, Day, Year) Hours Country) 218-40-6652 68 Director 1 M 2 X F MD April 19 1943 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location at 10d, Inside City Limits Director ems 23a or 28a-f sh r must be notified a MD Windsor Mill Baltimore 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 9511 Old Court Road 21244 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Examiner Armed Forces ō à 1 Never Married 2 X Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: white If Yes. Give "natural" Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) underwriter real estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Madeline Ridgeley with and Mental h Howard F. Cunningham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod. 9511 Old Court Rd., Windsor Mill, MD 21244 Mr. Paul S. Dorsey (spouse) 1 and 2 s of Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) All County Cremation |11-19-11 Sykesville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Parge Harget o P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition CardioThrombotic Event Onset and Death Ph\_sician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Cardiovasiular Distast Atherosclerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami ig physician and as the burial-transit Cause (Disease or injury execute that initiated events resulting in death) Last Due to (or as a consequence of) physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☑ No f Month Day Year the 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has autopsy page performed?/ Yes 2 No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 4 Nursing Home 5 Residence 6 W Other (Specify) 2 No 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) nours after death.

neral Director: After the filled in by the funera 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hot To the Funer completely fi 29a, Certifier 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) VISTAY APAMENID D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N S Ray apakit M.D 2835 SmtM AV Baltimore MD, 21209 S 203 · S · Rajapakie, M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37041 Certificate of Death 3. Time of Death 2. Dete of Death 1. Decedent's Name (First. Middle, Last) Month Day Year **Physician** 2011 2:30pm (November 19m /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, give street and number) Examiner Linthicum If Under 24 Hrs. Anne Arundel Chesapeake Hospice 8. Date of Birth (Month, Day, Year) Jan. 19, 1 If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** Hours 1<del>√</del>□ M 2□ F Months Yrs. 93 1918 Rhode Island 375-01-8609 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. Stete th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo MD Anne Arundel Hanover 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7728 Baggins Rd. 21076 USA Funeral Peges 1 and 2 should be filed within 72 hours efter death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 → Yes 2 → No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White WW II ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Electrician General Motors 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Department of Heelth and Mental Important: If frem 27 is marked or any injury or other traumetic events. William Entwistle Delora Terrio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7728 Baggins Rd., Hanover, MD 21076. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location (Son) <u>William E. Entwistle</u> 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Crematory @ Loudon Park 11/21/1 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner attending physician and I for use es the burial-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): Box 68760. Due to (or es e consequence of): resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. eral Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be deteched it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 11 Yes 22 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Hospice 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence Other (Specify) 1 Yes 2 No edical Certification: To 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injun Neturel 1 Yes 2 No 2 Accident efter death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funeral C completely filled Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 | Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier (Check only one)

State Registrar

DHMH 16 Rev 6/95

29b. Signature end title of certifie

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ho completed sause of de

32. Registrer's Signature

29c. License number

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29d. Date signed (Month, Day, Year)

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Examin			oss Hosp		7)		4b. City, To		Location o				c. County lonte	of Death omer	у
Funeral	70	5. Social Security N 242-23-9			Age (In yrs. la	ast birthday)	If Under 1 Months (	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da			9. Birth Coun	olace (State or Foreign try)
Director		Usual Residence of Decedent April												Nort	h Carolina
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	(Spe	15. Decedent's ecify only highest g ondary (0-12)	rade completed) College (1-4 c	or 5+)	(Give life. D	dent's Usual ( kind of work of O NOT use re	done d etired)	luring most	t of work	ing	16b. l		usiness/In	dustry
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permit. Departi Import any inji		21. Signature of Fu	neral Service Licer		>										Home,Inc. and 20785
Physician/		23a. Part 1. Enter the shock, or head immediate Case disease or condition	rt failure. List only (Final	nplications that causone cause on each	sed the deat line. R CIRE		er the mode o	of dying	g, such as	cardiac d	or respiratory a	rrest,			Approximate Interval Between Onset and Death
Medical Examiner		resulting in death)	ſ		as a consequ										
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te be exec nysician ai he burial-t	ا جا	resulting in death)	Last	Due to (or a	as a consequ	uence of):	CERTIFICATION APPROVED BY						Richman		
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1										23d. Date of delivery Month Day			
uires that the signed by all the detail	þ	Part II. <b>Other signi</b> t	ficant conditions	contributing to deat	h but not res	sulting in the u	underlying cau	use giv	en in Part	l.					ne cause of death?
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Physician: T this certifica and director, p	인		<del>XNo</del>			ER/Outpatie		Othe	er: 4 🗌 Nu	ursing Ho	ome 5 🗌 Resi	dence	6 🗌 Othe	er (Specif)	')
eath. or: After t the funera	Certificate:	27. Manner of Death  1 X Natural 2 Accident 3 Suicide	th 5 Pending Investigation 6 Could not	on	njury <i>Day, Year)</i> :	28b. Time of injury	M 28c	injury work 1 🗆			28d. Describe	how inju	ry occurre	ed	
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the Hosp nin 24 hou the Funei npletely fi	Medical	(Check 2 only one) 3	2 ☐ Medical Exam 3 ☐ Certifying Nu	ysician: To the best niner: On the basis of rse Practitioner: To	of examination	n and/or inves	tigation, in my	opinio v	on, death oc	curred at	t the time, date	and plac	e, and due	e to the ca	use(s) and manner stated
North Con		29b. Signature and	title (t/ceylifier)	Zel	b 1	)			number				_		Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 30A M CON DV Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ortho HMOR 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min **Director** 1 M 2 🗆 F 80 28a-f show 10c. City, Town or Location be filed within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10d. Inside City Limits Director 1 Ves 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 21222 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armer Forces?

1 Yes 2 If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 Married þ 2 No Maryland 21215-0036 1 Yes 2 No Completed 3 Widowed 4 Divorced Korea Specify 15. Decedent's Education 16a, Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 t.
Department of Health and Mental Hygiene.
Important If item 27 is marked other than "na any injury or other traumatic event, the Market once. 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End Physician disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of). the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months? Year 5 Other (specify) Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy After this certificate 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Deat (Check only one) examiner? Hospital: 2 M No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? within 24 hours after death. To the Funeral Director: A 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar MD-21221.

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31. Date filed (Month, Day,

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene

		1	For State Of IVIA  State Registrar		tificate of Dea	th and Mental Hyg th	Reg. No. 901-1-97-01-1-
	Physician	_	. Decedent's Name (First, Middle, Last)			2. Date of Deat Month	Day Year
)	Medic Examine	al _	Ellsworth Debny Ferrell  a. Facility Name (if not institution, give street and number)  6207 6444 Avenue	#/	4b. City, Town, or Loca	ation of Death	4c. County of Death Prince George's
	Funeral Director	5		(In yrs. last birthday) 4 Yrs.		Jurs Min. 8. Date of Birth Jurs Min. (Month, Day August 29	9. Birthplace (State or Foreign
	>	P P	Jsual Residence of Decedent	10c. City, Town or Loc <b>Riverdale</b>			10d. Inside City Limits 1 ☒ Yes 2 ☐ No
	vith the Ma 23a or 28a ist be notif	eral Dire	10e. Street and Number 6207 64th Avenue Apt.#1		10f. Zip Code 20737		10g. Citizen of What Country? U_sS.
36	within 72 hours after death with the Maryland glene. glene. et than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at , the Medical Examiner must be notified at	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Examed Forces?  1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 1 Yes 3 1 Yes 3 Yes or Dates.	le l	Was Decedent of Hispan If Yes, specify Cuban, Mi 1 □ Yes 2 🎛 No Sp	ic Origin? (Specify Yes or No- exican, Puerto Rican, etc.) pecify:	14. Race - American Indian, Black, White, etc. Affician American Specify:
Maryland 21215-0036	hin 72 hours ne. than "natur e Medical I	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5-	(Give life. D	dent's Usual Occupation kind of work done during OO NOT use retired) OR Plumber	g most of working	16b. Kind of Business Industry  DC WASA
and 21	e filed v tal Hyg ed othe event,	ایما	17. Father's Name (First, Middle, Last) Ellsworth Ferrell	rasu	18.	Mother's Name (First, Middle, Susan McMillian	Maiden Surname)
	2 shoulth and 27 is not traum	-	19a. Informant's Name/Relationship (Type, Print)  Marsairah Ferrell-Daughter	19b. Maili 6165 (	ing Address (Street and I	Number or Rural Route Numbe , Riverdale, MD 2	er, City or Town, State, Zip Code) 20737
Baltimore,	Page 1 and 2 s nent of Health ant: If item 27 iny or other tra	9	20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Riverdale 1	Park Crem.	Date 11–21–11	20c. Location - City or Town, State  Rivercale, MD
Balti	permit, Page 1 Department of Important: If any injury or any injury or or once.		21. Signature of Funeral Service Lice is le	-	2504 28th Stre	et, N.E., WDC 200	
	Physician/ ) Medical		23a Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death)  Due to (or as a Due to (or a) Due to	the death. Do not ends.  Sclerot a consequence of):	ter the mode of dying, st	ascular Ite	Approximate Interval Between Onset and Death
	Examiner	niner	Sequentially list conditions, if any, leading to initial data cause. Enter Underlying	a consiguence off:			
_	ate be executed ohysician and the burial-transit	dical Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last  C. Due to (or as	a consequence of):			
Box 68760	sician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transi	Completed by Physician/Medi	IF FEMALE:   23c.   If yes, outcome   23b. Was decedent pregnant   1	2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
P.O.	es that the signed by th	d by Phy	Part II. Other significant conditions contributing to death t	out not resulting in the	e underlying cause given	- 4	tobacco use contribute to the cause of death?  Yes 2 \( \sum \) No 3 \( \sum \) Probably 4 \( \sum \) Unknown
Division of Vital Records,	The law requii ate has been page 2 should	omplete				per	s an opsy formed?  24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
tal B	ysician: The second is certificated director, pa	Be	25. Was case referred to medical examine Hospital:		Othor	e of Death (Check only one)	C Other (Coopin)
n of Vi	ng Phys fter this ineral di	sate: To	1	ury 28b. Time injury	of 28c. Injury at		how injury occurred
ivision	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	4 Homicide determined building, e	jury - At home, farm, s tc. (Specify)		City or To	(Street and Number or Rural Route Number, own, State)
ш	Hospita 24 hours Funeral eted fille	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of Medical Examiner: On the basis of Only one) 3 Certifying Nurse Practioner: To the				
	To the within 2 To the comple	2	29b. Signature and title of certifier	10 20	29c. License n		29d. Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of	death (Item 23a) (Type	e, Print) Hospita	12-1-26	Le venta Manhad
<u>م</u>		ate trar	31. Date filed (Month, Day, Year) 32. Regist	trar's Sphature	les pilos	Correce, O	7, 4, 4, 6,000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37045 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joel Curry Greer Jr. Month 3:15 PM November 17 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital of Baltimore Baltimore . Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 217-24-4598 **Director** 1X M 2 G F 81 March 2 1930 TN Usual Residence of Decedent 28a-f shov 10a. State 10b. Count 10c. City, Town or Location notified at 10d. Inside City Limits by Funeral Director MD Carrol1 Taneytown 1 Yes 2 XNo 10e. Street and Number ms 23a or must be n 10f. Zip Code 10g. Citizen of What Country? 3305 Kump Station Road 21787 USA items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, item 27 is marked other than "natural", or itelether traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 No 1948 If Yes, Give Year or Dates. ਰਿ⊀ਟਵਨ ਹੈ∘ਵ∟ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐X No Specify: Specify: white Completed 3 - Widowed 4 - Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) agriculture farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Department of Heath and Menta Important if item 27 is marked any injury or other traumain once. မ Joel Curry Greer Sr. Beulah Cauldwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan I. Greer (spouse) 3305 Kump Station Rd., Taneytown, MD 21787 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Mt. View Cemetery 11-22-11 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Dag Saight Herbert <u>Box 195 Sykesville, MD 21784</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Acute unocardial infarction disease or condition resulting in death) 5 days Medical Due to (or as a consequence of): **Examiner** Coronary artery 20 years Sequentially list conditions, if dry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami burial-transit resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 1 Yes 2 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes mellitus 1 ☐ Yes 2 ♠No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No certificate 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: Nwithin 24 hours after death.

To the Funeral Director: After this certification of the Funeral Director. After this certification of the Funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) Peter N. Cho, M.D. Surgeon D41129 November 17, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Peter W. Cho, M.D.

32. Registrar s Signatule

2435 West Belvedere Avenue

Baltimore, Maryland 2/215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37046 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ Month tnacla () 1640 M Medical . Facility Name (if not institution, give or Location of Death Examiner County of Death Mary Homore altimore wiversity Social Security Number If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In vrs. last birthday) 8. Date of Birth **Funeral** Month Hours 174-68-9640 **Director** 1 □ M 2 🔽 F 29 Yrs 5-1-1982 PENNA. Usual Residence of Deced 28a-f show 10a State 10c. City, Town or Location within 72 hours after death with the Maryland at 10d. Inside City Limits Director items 23a or 28a-f s er must be notified 1 X Yes 2 No PENNA. DAUPHIN MIDDLETOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1039 PLANE ST. 17057 IISA 11 Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1X Never Married 2 ☐ Married o, þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. WHITE "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha the UNEMPLOYABLE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ JOSEPH D. GUSLER HELEN I. VISKI traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is rany injury or offer HELEN I. GUSLER (MOTHER) 1039 PLANE ST. MIDDLETOWN. PENNA 17057 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burjal 2 X Cremation 3 X Removal from State BFH CREMATORY 11-18-2011 GRANTVILLE, PENNA. 4 Donation 5/ Other (Specify) D. HIBNER Name and Address of FacilityMATINCHEK & DAUGHTER FUNERAL HOME JONATHAN 260 E. MIDDLETOWN. MAIN ST. PENNA 17057 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph. i i n disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine burial-tran that initiated events resulting in death) Last Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months?
1 ☐ Yes 2 🗷 No Pregnant at time of death the Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Jas certificate 2 No Yes 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) xaminer? 1 Yes Hospital Other: 2 🗆 No |2 1 Unpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. Natural injury work?
1 Yes 2 No 5 Pending ieral Director: A filled in by the fu Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) R107416 11.17.11 (Item 23a) (Type, Print) South Greene Street Saltimore, MD 21071 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Registrar

State of Maryland / Department of Health and Mental Hygiene

25 per me,g921,11/18/2011dh

Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ANN GREEN ADELE Month 2011 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FRANKLIN Square Hospita. Baltimore Losedale Social Security Number 6. Sex 7. Age (In vrs. last birthday) Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Min (Month, Day, Yea -5-1948 NEW YORK 063-42-9023 Hours 63 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE MIDDLE RIVER 1 Yes 2 No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? with Funeral 113 TRAILWAY ROAD 21220 U.S.A. "natural", or items should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2X Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: WHITE Completed 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. HOMEMAKER OWN HOME Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ JOSEPH Ε. DEMMER PEARL В. WILCOX ) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sh tment of Health a tant; If item 27 is jury or other tra THOMAS GREEN/HUSBAND 113 TRAILWAY ROAD MIDDLE RIVER, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of IImportant: If ite
any injury or ott 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) METRO CREMATORY 11-17-11 CATONSVILLE, . Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated exacts. Examine Due to (or as a consequence of) ON APPROVED BY MEDICAL EXAMINER Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) for in the past 12 months?
1 Yes 2 No Month Day Year signed by the ar 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' this certificate 2 🔽 1 Tyes 2 No Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending wor 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation 24 hours after deat Funeral Director. completed filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I only one 29b. Signature and title of certifig 29d. Date signed (Month, MS 0000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

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31. Date filed (Month, Day, Year)

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32. Registrar's Sidnature

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NOV 1 8 2011

Baltimone

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month 845 A 2011 Clay Hawks , Jr. Henry Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death FRANKLIN Saugre Hospital Roseda Baltimore 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Hours Min 220-36-8931 **Director** 1 **X**M 2 □ F 70 Yrs. 10/11/1941 Virginia Usual Residence of Deceden 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 913 Garden Drive, Apt. 2B 21221 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 XNo If Yes, Give Year or Dates 1 Yes 2 X No Specify Specify: Completed 3 Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Helper Electrical Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Henry Clay Hawks, Sr. June Gay Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Gay Reynolds (Mother) 5 Crafton Road, Essex, Maryland 21221 20a. Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 $\stackrel{\mbox{\scriptsize M}}{\mbox{\scriptsize M}}$ Burial 2 $\square$ Cremation 3 $\square$ Removal from State Glen Haven Mem. Park 11/22/2011 Glen Burnie, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. Signature of Funeral Service Lic 1407 Old Eastern Avenue, Essex, Maryland 21221 Part Leater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. malnutrition protein calorie dease or conunction sulting in death) ase or condition Severe Medical Due to (or as a consequence of) Examiner 0.9.0 Sequentially list conditions, if any leading to immediate Examiner Due to lor as a conse uence of cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit afferent Syndrome LOOD and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ for in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 L g Unknown 2 🗆 No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed death? 2 🗌 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

death certificate be Box 68760 Division of Vital Records, P.O. 24 hours after death Funeral Director: After this To the Hospital or Attending filled in by the within 2

Maryland 21215-0036

Baltimore,

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31. Date filed (Month, Day, Year) State

Medical

29a. Certifier (Check

only one)

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

RES0000

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

md 21237 9000 FRANKLIN Square DR Balto

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

DR Sharon

NOV

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Mont 1608 PM USA, Y, JORDAN 201 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death N/A BALTIMORE UNIVERSITY OF MARYLAND MEDICAL SYSTEMS 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 216-86-8448 1 □ M 2 **Y** F 39 Maryland Aug. 3, 1972 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 □ No MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21202 1000 E. Lombard Street Apt. 203 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Black If Yes, Give 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry Housing Authority 16a Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Building Monitor of Baltimore City 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Evonne Vass Lee Jordan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4403 Asbury Avenue Baltimore, Maryland 21206 Evonne Vass - Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 M Burial 2 Cremation 3 Removal from State 11/11/2011 Baltimore, Maryland Oaklawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Liceries & aluen 4210 Belair Road Baltimore, Maryland 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final END-STAGE LIVER DISEASE disease or condition resulting in death) Due to (or as a consequence of 2 weeks MULTI-ORGAN FAILURE Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to for as a nonteigname of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Month Day the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown HEPATITIS B 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy

Physician Medical Examiner

Physician/

Medical

Examiner

**Funeral** 

**Director** 

or 28a-f show notified at

"natural", or items 23a or edical Examiner must be

the Medical

other traumatic event,

al Hygiene.

and Mental His marked o

Department of Health and Monti Important: If item 27 is marked any injury or new

death

3altimore, Maryland 21215-0036

Director

Funeral

by

Completed

Be

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attending physician and I for use as the burial-transit Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death

has

Examine Physician/Medical Completed by page 2 ours after death.

eral Director: After this certificate I filled in by the funeral director, pag Be ٥ Medical Certificate:

27. Manner of Death

29a. Certifier only one)

F FEMALE: :3b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗶 No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death g ☐ Unknown
Part II. Other significant condition	s contributing to death but not resulting in t

25. Was case referred to medical examiner? Hospital 1 Yes 2 No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Minpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No iniury

5 Pending ➤ Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 St Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

performed?

29b. Signature and title of certifier

1104115963

29d. Date signed (Month, Day, Year) 11, 3, 2011

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SOWMYA RAVIMD/22 S. GREENEST. /BALTIMORE/MD/2120)

State Registrar

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Date filed (Month, Day, Year) 32. Registrar's Signature 1. Jack

within 24 hours a

To the Funeral C

completely filled

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(	he dee	1,000		1 Yes 2 9 Unknown	_  No		9 Unk		inte or a		J	(Spoony)									
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	DIVISION Of VItal KECOrds, P.O. BOX 68/60 e Hospital or Attending Physician: The law requires that the death certificate be n.24 hours after death.  e Funeral Director: After this certificate has been signed by the attending physici lefely filled in by the funeral director, page 2 should be detached for use as the by	Logical	29	(Check 2	X Certifying Medical Ex	caminer:	On the bas	sis of exa	mination	and/or in	vestigation,	in my opini	on, death o	occurred at	the time, date	and place	ce, and du	e to the	cause(s) and	manner state	d.
	To the within 2 To the comple	2		only one) 3 o. Signature and	title of certifier	Nurse Pr	actitione	r: To the l	best of m	ny knowled		occurred at 29c. Licens		late and plac	ce, and due to				s stated. h, Day, Year)		-
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ndrew M. Johns		1- For State Certificate of Death Reg. No. 20	11 370
Physicia ledical Examir	in/ ner	1. Decedent's Name (First, Middle,Lest)  2. Date of Death  Month Day Year	3. Time of Peath 2316 hrs
Funeral Director	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYYY) 9. Months Days Hours Min. 7 / 28 / 1 986	Birthplace (State or reign Country) MD
daryland 28a-f show any 1 at once.	Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MD Anne Arundel Glen Burnie  10e. Street and Number 10f. Zip Code 10g. Citizen of What Code 134 Sloan Drive Apt F. 21061 USA	10d. Inside City Limits 1 Yes 2 No country?
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f abort other traumatic event, the Medical Examiner must be notified at once	by Funeral Dir	11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2 No  No  1 Yes 2 No specify:  1 Yes 2 No specify:  1 Yes 2 No specify:	ack
215-0036 be filed within 72 hours a ntal Hygiene. rked other than "natura ent, the Medical Exami	Completed b		
MD 21215. d 2 should be filed the and Mental Hy n 27 is marked of numatic event, the	To Be	Jay Rodney Sylvia Johnson  19a. Informant's Name/Relationship (Type, Print)  Sylvia Johnson  7838 Freetown Rd Glen Burnie.	MD 21060
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical injury or other traumatic event, the Medical		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Phillip A Weather	e <u>Balte</u> e <u>Md</u> rford FS
Physician Wedical Examiner		2431 E. Oliver Street Balto  23a. Part I. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Gunshot wounds (2) of Torso  Due to (or as a consequence of):	Approximate Interval Between Onset and Death
	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
O, e be executed sician and burial - transit	edical Ex	a a	Nept .
Box 68760, to death certificate be ex the attending physician and for use as the burial.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	Day Year
IS, P.O. B quires that the d en signed by the	Š	1 Yes 2 No 3	Probably 4  Unknown  e autopsy findings available
of Vital Records, P.C. ing Physician: The law requires that After this certificate has been signed inneral director, page 2 should be dete	e Completed	25. Was case referred to medical 26. Place of Death (Check only one)	to completion of cause of h? Yes 2 No
	ation: To Be	1 Yes 2 No 1 Inpatient 2 PROutpatient 3 DOA 4 Nursing Hollie 3 Neside to 5 Country at Work? 28d. Describe how injury occurred	Other:
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	cal Certification:	298, Certifier 4   County to a Physician. To the heat of my knowledge death eccurred at the time, date and place, and due to the cause(s) and manner as	rnie, MDstated.
To the within To the	Medical	The slow M. K. & TR. w. D. O.C.M.E. OCME November 14	(Month, Day, Year)
Ø	tate	30. Name and address of person who completed dause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  31. Date filed (Month, Day, Year) 32. Registrar's Signature	

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1acceson Ŧ 7:49 November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death SECOURS Hospital Balhmore Homore 5. Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign L(Month, Day Hours Min. Director 32-8678 Usual Residence of Decedent "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director trmore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral Orkwoo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည ackson 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traconce. tricke 122 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Funeral Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that a shock, or heart failure. List only one cause on the first only one cause on the first one cause of the f ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ 10 disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical death certificate be Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Pregnant at time of death signed by the a 2 No 9 Unknown Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires within 24 hours after death.
To the Funeral Director; After this certificate has been sign Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page Yes 1 Yes Be 25. Was case referred to medical Division of Vital the funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? injury 5 Pending 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number

37 5

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary Gentile Krein Month 12:50 Рм November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Village Baltimore Parkville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Sept. 22 1912 1 🗆 M 2 🗓 F Hours 99 215-03-2517 Maryland Director Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location 10a. State items 23a or 28a-f sho her must be notified at Director 10d. Inside City Limits death with the Maryland 1 🗆 Yes 2 🔀 No Parkville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8820 Walther Blvd. 21234 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, injury or other traumatic event, the Medical Examiner Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. 0 Completed by 1 Never Married 2 Married 1 ☐ Yes 2 XX No Specify: "natural", Specify: white 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other this any injury or other traumatic event, the 1 once. newspaper industry executive secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Eva Bavota Alfredo Gentile 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jolie K. Mitchell/daughter 18 Meadow Rd. Baltimore, MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery Nov. 19,2011 Baltimore, Maryland 21. Signature of Funeral Service Licenses Mitchell Wiedereld Funeral Home, Inc. 6500 York Rd. Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death ed by the detached 9 Unknown signed by a Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Sursing Home 5 Residence 6 Other (Specify) this : After thi 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work in 24 hours area. he Funeral Director, Aff 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

State Registrar

within 2

29a. Certifier

only one)

29b. Signature and title of certifier

Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11 13:50 PM

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 16, Physician/ 10:45AM <u>Pamela Faye Kellenberger</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner VINGE Baltimore Washington Medical Center Glen Burnie 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Florida **Director** 263-98-6491 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a State 10c City, Town or Location Examiner must be notified at Director Maryland | Anne Arundel 1 Yes 2X No Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral United States 21061 107 Main Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 5 p 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 Yes 2X No Specify: "natural", Completed 3 UVidowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Morningstar Foods Plant Worker 12 permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Artie Eugene Montgomery Lena Eldora Riley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Main Ave, Glen Burnie, MD 21061 Craig Kellenberger/ husband 20a Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State gerger 4 Donation 5 Other (Specify) 11/19/2011 Catonsville, Maryland Crematory Metro 21. Signature of Funeral Service Licensee Name and Address of Facility 0136 rkley-Ruddick Funeral Home 11 Crain Highway S.E., Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Examir ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death use 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 4 ☐ Pregnant: 9 ☐ Unknown 1 Lyes 2 g signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has page 2 autopsy 2 Yes Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Tes 2 No ၉ 1 Nonpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred or Attending 1 KNatural injury 5 Pendina 2 🗀 Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) building, etc. (Specify) the Hospital Medical 29a. Certifier 🕊 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3- Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature nd title of cen 29d. Date signed (Month, Dav. Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month

11-08693	
John W Kiser.	Jr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ohn W Kiser, J	Jr	State of Maryland / Department - For State Certificate			2011 3705
Physici		1. Decedent's Name (First, Middle, Last)		Date of Deat     Month	h 3. Time of Death
odical Exam	iner	John W. Kiser, Jr.  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of De	November ath	18, 2011 1025 fils
		Baltimore Washington Medical Center	Glen Burnie		Anne Arundel
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		tin	th(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director			Yrs.	Oct. 2	22, 1979 Country) Maryland
any		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Lo	ocation		10d. Inside City Limits
and show	  -	Maryland Anne Arundel Glen Burn	nie		1 Yes 2 X No
Maryland r 28a-f sho ed at once.	Director	10e. Street and Number	10f. Zip Code		Og. Citizen of What Country?
21215-0036 Mote filed within 72 hours after death with the Maryland Mental Hygiewei. marked other than "natural", or items 23a or 28a-f she e event, the Medical Examiner must be notified at once		1700 Pleasantville Drive  11. Marital Status   12. Was Decedent Ever in U.S.   13.	21061 Was Decedent of Hispanic Origin? (		United States  14. Race - American Indian, Black,
leath w r items tust be	Funeral		If Yes, specify Cuban, Mexican, Pue		White, etc.
after c	by F	3 Widowed 4 Divorced if Yes, Give Yeer or Dates:	Yes 2 X No specify:		Specify: White
6 n 72 hours an "natui			dent's Usual Occupation (Give kind of gmost of working life. DO NOT use it		16b. Kind of Business/Industry
DO36 within 73 iene.	Completed		enter		Building
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, Last)		me (First, Middle, N	faiden Surname)
21215 buld be fill Mental H marked c event, t	To Be	John W. Kiser, Sr.  19a. Informant's Name/Relationship (Type, Print)  19b. Ma	Linda :		ber. City or Town. State. Zip Code)
MD 3 nd 2 shou lith and m 27 is a	_		·		Burnie, MD 21061
re, land the land the land the land land land land land land land land			position (Name of cemetery, rother place)	Date vember	20c. Location - City or Town, State
Baltimore, permit. Pages I an Department of Hea Important: If ite		4 Donation 5 Other Specify: Loudon I		3, 2011	Baltimore, Maryland
Baltimore, MD 21 permit. Pages I and 2 should Department of the lath and Me Important: If item 27 is may injury or other traumatic ex-		21. Signature of Fun, rat Service Ificensee	2 Name and Address of Facility Kirkley-Ruddick F 421 Crain Hwy S	uneral H	ome, P.A. n Burnie, MD 21061
Physician		23a. Part. Enter the disease, or complications that caused the death. Do not ent failure. List only one cause on each line.			
Medical Examiner		Immediate Cause (Final disease a Combined drug (Methac	done&Alprazolam &	cocaine)	Davids Co. etc.
		or condition resulting in death)  Due to (or as a consequence of):			
	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause			
A	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
rand transii	ia E	d.    MENDED 23a, 27, 28a-f,	per me g923 1_2/i.	-12 cm	
50, te be execut y sician and burial - tran	ledical		per me, g 3 2 3 1 - 2 4	-12 5111	22d Date of delivery
Box 6876 e death certificate the attending phy ed for use as the l	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic preg	nancy	23d. Date of delivery  Month Day Year
Sox death or e atten for us	ysici	4 Pregnant at time of death 5 Unknown 9 Unknown	Other (Specify)		
of Vital Records, P.O. Box 6876 ing Physician: The law requires that the death certificate After this certificate has been signed by the attending phy timeral director, page 2 should be detached for use as the l		Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.		bacco use contribute to the cause of death?
S, P, uires th	ed by				2 No 3 Probably 4 Unknown
Division of Vital Records, rs and a Attending Physician: The law requirers and each. There is a Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed			24a. Was a autop:	sy prior to completion of cause of
Rec : The lificate lificate l	Con	25. Was case referred to medical	OC Plane of Double (Char	1 ✓ Yes 2	
/ital	o Be	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpati	26.Place of Death (Chec ent 3 DOA Other Nur	sing Home 5	Residence 6 Other:
ing Ph After t	n: T	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time			ow injury occurred
Sion Attend death. ector:	catic	Natural 5 Pending Investigation fd 11-18-11 fd 5:		unknown	
Divi	Certification:	3 Suicide 6 X Could not be determined (Specify) 28e. Place of Injury - At home, farm, so (Specify) residence	treet, factory, office building, etc.		treet and Number or Rural Route Number, City late) I 700 Pleasantville on, Burnie, MD.
Division of Vital Rec To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate the completely filled in by the funeral director, page?	al C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of		nd due to the cause	e(s) and manner as stated.
To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or invest and manner stated		d at the time, date a	
	2	29b. Signature and title of certifier	29c. License number O.C.M.E.	OCME	29d. Date signed (Month, Day, Year)  November 19, 2011
(DA		30. Name and address of person who completed cause of death (Item 23a)	φ.		
of the		Theodore M. King, Jr., MD. Assistant Medical Examiner	900 W. Baltimore Street,	Baltimore, MD	21223
Si Regis	tate	31. Date filed (Month, Day, Year) 32. Daystrar's Signature			

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death KOLODZIESKI, JR. JOSEPH RICHARD Physician/ NOVEMBER 17, 201 3:55P M Medical 4a. Eacility Name (if not institution, give street and number) WASHINGTON ADVENTIST HOSPITAL 4b. City TAKOMA PARK Examiner 4cPRTNCEth GEORGES 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Dav. Year) Min Months Days Hours 212-50-1093 62 **Director** 1**X** M 2 □ F 2-11-1949 MARYLAND Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland the Medical Examiner must be notified at Director GLEN BURNIE ANNE ARUNDEL MD 28a-f 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 23a 21061 U.S.A. 1004 GUY DRIVE items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Was Decesor...
Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ument of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: WHITE Completed 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry SOCIAL SECURITY Elementary/Secondary (0-12) College (1-4 or 5+) COMPUTER SPECIALIST ADMINISTRATION Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ KOLODZIESKI, AUDREY McQUAY SR. I. JOSEPH RICHARD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

CT.FN RIIRNIE. MD 21061 19a. Informant's Name/Relationship (Type, Print) 1004 GUY DRIVE KARLYN KOLODZIESKI/WIFE 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 X Burial 2 Cremation 3 Removal from State GARDENS OF FAITH 11-22-11 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME Signature of Funeral Service Licensee 21237 1211 ROSEDALE, CHESACO AVE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between on et and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence on, the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death signed by the at Id be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 4 Dunknown 2 No 3 Probably Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 24 hours after death. Funeral Director: After this certificate has filled in by the funeral director, page 2 1 Yes 2 No 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 2 X No 1 🕅 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA ၉ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Medical Certificate: 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury Natural 5 Pending Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) 🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one)

State Registrar 29b. Signature and title of certifier

d address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

29c. License number

29d. Date signed (Month, Day, Year)

alcoma

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 37057 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ <sup>Day</sup> 7, 2011 8:19 A Geoffrey NOvember Thomas Keating Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Center Towson If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Min **Director** 1 X M 2 □ F 011-22-6420 81 June 10, 1930 Massachusetts Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits notified at Director 1 Yes 2 X No **Baltimore** Timonium Maryland | 10f. Zip Code 10g. Citizen of What Country? ö the Medical Examiner must be 23a Funeral 21093 2112 Fountain Hill Drive or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. by 1 Never Married 2 X Married X Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", If Yes, Give Specify. 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with h and Mental Hygien is marked other th 04 Insurance Manager injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Keating Mary Twomev Walter Gregory 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Jean A. Keating/Wife 2112 Fountain Hill Drive, Timonium, MD 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11/21711 1 X Burial 2 Cremation 3 Removal from State 4 Denstion 5 Other (Specify) Dulaney Valley Memorial Gardens Timonium, Maryland 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 the death. Do not eiter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death e disease, or complications that cause failure. List only one cause on each lin nter th Immediate Caus (Final Physician/ disease or Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and initiated sevents.) Due to (or as a consequence of): the burial-trar Due to (or as a consequence of): ŵ resulting in death) Last physician Physician/Medical death certificate be Box 68760 attending p yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Second at time of death 5 Other (specify) IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year Yes 2 No ed by the a g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ Probably 4 ☐ Unknown 1 Yes 2 No Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2**X** No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined cal 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Certifying within 2 only one 29b. Signature ar Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 1235 Ам harles NOV Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Days Hours May 8, 1925 219-18-3955 86 MaryTand Yrs Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director MD 1 🗆 Yes 2 🙀 No Worcester Berlin 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a 6 Spruce Ct. USA 21811 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. b þ 1 Never Married 2 X Married 1 x Yes 2 □ No If Yes, Give 1.π Maryland 21215-0036 1 Yes 2 X No Specify. "natural", Year or Dates. WW II Completed 3 Divorced 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Refinery Chemist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental I **7 is marked** o ပ J. Krause, Sr. Charles Spiegel injury or other traumatic Helen S. 19a. Informant's Name/Relationship (Type, Print) Department of Health as Important: If item 27 is any injury or other traunonce. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Krause (Wife) 6 Spruce Ct., Berlin, MD 21811 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Loudon Park Cemetery: 11/14/11 Baltimore, Maryland 21. Signature of Funeral Service Lansee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1 Enfer the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, effect, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ubaracho disease or condition resulting in death) Medical Examiner days Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or Exam Hospital or Attending Physician: The law requires that the death certificate be executed and tran resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No ò Month Day Year 1 Yes 2 9 Unknown the 8 9 Unknown signed by t d be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 perform Yes 2 No 1 Yes 2 No After this certification of the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🔀 No 1 Yes မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu Accident 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practionary 1. This was of my knowledge does not make the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practionary 1. This was of my knowledge does not make the time, date and place, and due to the cause(s) and manner as etched. 29b. Signature and title of certifier A.W. 9900 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ndall Greeve St ۶. 32. Registrar's Signature State Registrar

			For State Registrar	Plea	se Type or State of			l / Depa	delible Inkartment of F artment of F	lealth and	_		e วกเ	e.	37059
	Physici /Medi		1. Decedent's Nam	ne (First, Middle ALFRED	e, Last)						2. Date of I Month	Death		ear	3. Time of Death
and the same of th	Examir		Good Samaritan Hospital Baltimore No.										c. County of None		
	Funeral Director		5. Social Security 1 218–28–6791		6. Sex M 2□ F	7. Age 80	(In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		Birth Day, Yea 931	r) 9	. Birthpla Count Mar	ace (State or Foreigr ry) yland
	ryland show	_	Usual Residence of 10a. State	10b. County				Town or Lo	cation					10	d. Inside City Limits
	the Marylar 28a-f show	Funeral Director	Maryland 10e. Street and Nu	None			Baltimore   10f. Zip Code   10g. Citizen of W								Yes 2□No
	ath with 23a or	ral Di	321 Broadm				21212					USA			
980	be filed within 72 hours after death with the Maryland ntal Hygiene. sd other than "natural", or items 23a or 28a-f show event, the Marical Examinant country to market.		11. Marital Status 1 ☐ Never Mari 3 ☐ Widowed		ied Armed F	es 2 □ No 190∠			Was Decedent of H fYes, specify Cuba I□Yes ※XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	(Specify Yes or lerto Rican, etc.)	No-				
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212	filed within Hygiene. ther than "	Completed by	Elementary/Seco	ondary (0-12)	College (	1-4or 5-	+)		les Enginee	,			Oil		
Baltimore, Maryland 21215-0036	should be filed vand Mental Hygic s marked other umatic event, II	ø	John Thomas	17. Father's Name (First, Middle, Last)  John Thomas Long  18. Mother's Name (First, Middle, Maiden Surname)  Helen Fitzpatrick											
Mai	od 2 lift i		19a. Informant's N Regina Eage		nip <i>(Type. Print)</i>	Wif	fe		ig Address <i>(Street</i> O <b>admoor Ro</b> a			_		ate, Zip (	Code)
ore,	S to the D		20a. Method of Dis	position	3 Removal from		20b. Pla	ce of Dispo netery, cren	sition (Name of natory or other plac	e)	Date	20c.	Location - Ci	•	
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		1	23a. Part 1. Enter	the disease, or	complications that	caused	the death.	Do not ent	6500 York er the mode of dyir				d 21212		Approximate
4	Physician		Immediate Cause disease or condition	art fallure. List (Final on	only one cause on	each lin	е.	1.0	YEUMO						Interval Between Onset and Death
8760, &	cate be executed by physician and the burial-transit the burial-transit	dical Examiner	resulting in death)  Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated event resulting in death)	onditions, nmediate erlying r injury s	b. Due to	(or as a	a conseque	VASI Ince of): CIBR	CLLATIO,	Y.	ENT				
O. Box 687	The law requires that the death certificate be exate has been signed by the attending physician age 2 should be detached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months? □No		birth a	of pregnand 2 ☐ Fetal d time of dea	leath 3	Ectopic pregnanc Other (specify)	y		-	23d. Date o Month		ry Day Year
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f Vii	Physician: r this certifica ral director, p	To Be	examiner?		Hospital:	Inpatier	nt 2□El	R/Outpatien	t 3 DOA Oth	or:	leath <i>(Check onl</i> 3 Home 5 ☐ Re		6 ☐ Other	(Specify)	)
o uc	ding PI I. After ti funeral	ion:	27. Manner of Dear	5 Pending	9 1	of Injur oth, Day	y ; Year) 2	8b. Time of Injury	28c. Injur Work	y at ⟨? Yes 2 □ No	28d. Describ	e how inj	ury occurred		
Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	2' ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investig 6	not be 28e. Place	e of Injui	ry - At hom . <i>(Specify)</i>	ie, farm, stre	eet, factory, office	765 Z	28f. Location City or 7	(Street a own, Sta	and Number te)	or Rural	Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only one)	1⊠ Certifyin 2□ Medical	g Physician: To the Examiner: On the i and mar	pasis of	examination	ledge, death on and/or in	occurred at the tile vestigation, in my o	ne, date and pla pinion, death or	ace, and due to to ccurred at the time	ne cause e, date a	(s) and mann nd place, and	ner as sta d due to	ated. the cause(s)
	To the vithing to the complete	Me	29b. Signature and	ritule of certifier	af, mo				29c. Licens			29d. E	oate signed (I	Month, D	ay, Year)
	8		30. Name and add	ress of person	who completed cau	se of de	eath (Item 2	23a) (Type, 1							,
	Sta Registr		31. Date filed (Mon	nth, Day, Year) 1 2011	Secretary 32. F	Registra	r's Signatu	re Carlo							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 's Name (First, Madie, Last) Month Dav Physician/ ambson Ovembe Medical Facility Name (if not institution, give 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore mari If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth . Age (In yrs. last birthday) **Funeral** Month day, 1 №M 2 🗆 F 58 Month Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location Director notified 1 les 2 la No timore 28a-f 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a o 21229 Funeral 830 USA ane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 Yes 2 No þ 1 Yes 2 No Specify: If Yes, Give Completed 3 Divorced 4 Divorced Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during life, DO NOT user tired) 15. Decedent's Education (Specify only highest grade completed) th and Mental Hygiene.

7 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Be Maryland filed 17. Father's Name (First, Middle, Last) Department of Health and Should be Department of Health and Menta Important: If fem 27 is marked any injury or other traumatic emone. မ ambson (Street and Number or Rural Route Number, City or Town, State, Zip Code) informant's Name/Relationship (Type, Print) (Wife ambson altimore, Place of Disposition (Na 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final air Embolism Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): ATTON APPROVED BY MEDICAL Examiner central Sequentially list conditions, if any leading 15 immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to for as a conse uence of anding physician and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit urosepsis CERTIF Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Spinal Stenosi Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Daraplegi autopsy performed 1 Yes 2 40 morbid obesu Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) Hospital: 2 W No ٩ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident work? 1 ☐ Yes 2 ☐ No iniury 5 Pending Central line placement 0125 M Investigation November 17,2011 3 Suicide 4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5601 LOCH RAVEN BIND BAHIMORE determined Baltimore, MD Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0062689 November 17, 2011 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) 0 athleen hat 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Jarke Registrar

DHMH 17 Rev 7/2009

Patient known os Carmela Leone

			Pleas Amend Item	se Type or Pri 23a Pt1, I State of M	nt in Bl	lack In	delible In	<b>67266</b>	All Copie	s Are Leg	gible.	
			For State Registrar	State of M	aryianu		tificate of L		wientai riy	Reg. No. 2		37061
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and the same	Medic Examin		4a. Facility Name (if not institution, g	ive street and number)				r Location of Dear	<u></u>	4c. Count		119.00
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	Funeral Director		150-14-4744 Usual Residence of Decedent	1 □ M 2 <b>X</b> ]F	84	Yrs.	Months Days	Hours Min	. (Month, D		Cour	
	/land f show ed at	tor	10a. State 10b. County		50.0	Town or Loc					1	0d. Inside City Limits 1 ☐ Yes 2 No
	the Man or 28a- e notifie	Director	Maryland Balti  10e. Street and Number		паг	npstea	10f. Zip Code			10g. Citizen of U.S.A	What Cour	
	th with the ns 23a must be	Funeral	18609 Brick Stor			40.14		074	`if- \/			
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Deplatment of Health and Mental Hygiene.  Important If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at one.	ed by Fu	11. Marital Status 1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	Ever in U.S.	lf If	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 No	an, Mexican, Puer	to Rican, etc.)	Bla	ce - Americ ck, White, : Whi	etc.
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, Maryland	id 2 should saith and M n 27 is ma er traumai		19a. Informant's Name/Relationship Andrew C. Leone,		and	19b. Mailin <b>1</b> 8609	g Address (Street Brick S	and Number or R tore Rd.	ural Route Numb Hampste	er, City or Town,	State, Zip ( 2 <b>107</b>	Code) 4
Baltimore,	Page 1 ar ment of He tant: If iten lury or oth		20⊈. Method of Disposition  1   Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spo		cerr	netery crem	sition (Name of eatory or other place alley Met	cer	12#2011 ns	20c. Location Timoni		
Balt	Depart Import any in		21. Signature of Funeral Service Lic	ensee			Name and Addre					1 P.A. D. 21117
			23a. Part 1. Enter the disease, or conshock, or heart failure. List only	omplications that causer y one cause on each lin-	d the death. I	Do not ente		ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
	Plysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	vivoud.	, fug	Value	the Abd	ominal A	Aorta	-	Onset and Death
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	e executed slan and urial-transit		that initiated events resulting in death) Last	c. Due to (or as	a consequen	ice of):			PPROVED BY M	EDICAL EXAMINE	`	
68760	icate be physicas the b	ledic		d		_		CERTIFICATION				
Box 68	Hospital or Attending Physician: The law requires that the death certificate be 24 hours affer death.  24 hours affer death.  25 hours affer death affer this certificate has been signed by the attending physiciately filled in by the funeral director, page 2 should be detached for use as the butterly filled in by the funeral director, page 2 should be detached for use as the butterly filled in by the funeral director.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal d	leath 3 🗌	Ectopic pregnand Other (specify)	су		- 1	ate of deliv	ery Day Year
P.O.	s that the		Part II. Other significant condition	s contributing to death to	out not result	ing in the ur	nderlying cause gi	ven in Part I.				ne cause of death?
Records,	requires been sig should b	Completed by	Missal Cale	The Alla	110 00	n hi	Mararia	-	24a. Was		Were auto	psy findings available
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Division	al or At s after o	Cerl	4  Homicide determin	ed 28e. Place of Injury		e, farm, stre	et, factory, office			wn, State)	er or Hura	Houte Number,
_	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director, After this completely filled in by the funeral di	Medical	(Check 2 Medical Ex	Physician: To the best of aminer: On the basis of elements of the basis of the basi	examination a	nd/or investi	gation, in my opini	on, death occurred	at the time, date	and place, and di	ie to the ca	use(s) and manner stated.
	To the within To the comple	Σ	29b. Signature and title of certifier			r. Williams	29c. Licens	e number		29d. Date signe	ed (Month,	Day, Year)
			▶ laxnů H.	Tyes, ME		20) /Time D		3009		Novem	beh	7 2011
-			30. Name and address of person white Lax Mu + I = Tu	ier, MBB	35 -	Smai	5	tal of	Baltin	iore		
4	Sta	te	31. Date filed (Month, Day, Year)	82. Registr	ar's Signatur	e de la	, ,	4)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10a per fh g921 11-21-11 vt.
State of Maryland? Department of Health and Mental Hygiene 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 16, Physician/ 2011 5:30 Mike Moxley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral ▼** M 2 □ F Addist 0-25 ear 1962 49 217-66-3044 Mary Land **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits XX 1 ☐ Yes 2 ☐ No must be notified at Director Glen Burnie Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō by Funeral 23a USA 21060 7061 Ingram items ; 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. the Medical Examiner Black, White, etc. 1 X Never Married 2 Married 9 Maryland 21215-0036 1 ☐ Yes : 1 ☐ Yes 2 🛣 No Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Programmer 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) College<sub>1</sub>(1-4 or 5+) NSA Ith and Mental Hygie 27 is marked other r traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Earl Moxley Bertha Canoles permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print)
Bertha Moxley Mother 19b. Mailing Address (Street and Number or Rural Route Nur. ber, City or Town, State, Zip Code) 821 W. 34th Street, Baltimore , Maryland 21211 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Cemetery 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 11/21/2011 Baltimore, Maryland <sup>22</sup> Name and Address of Facility Burgee Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland Signatury of Funeral Service Lic 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cardiovascular Collapse

Due to (or as a consequence of): Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events perlipidemia burial-transit Due to (or as a resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Year 1 Yes 2 No ed by the a detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. After this certificate has been signed funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by Obesity Division of Vital Records, 1 Tes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No death? 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: မှ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No e Hospital or Attending Pl 24 hours after death. e Funeral Director: After th 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. othe Hu within 27 (Check only one) 29b. Signature and sitle 29d. Date signed (Month. Day, Year) D0058860 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. CAlvert Street State NOV 2 1 2011

OHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Eileen D. Magness 4:16 PM JUIGNAGE 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** n/a BALTIMORE ARNES HOSPITAL 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. 9 / 7 / 19 19 218-09-9249 Director 92 Marvland Usual Residence of Decedent show 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director Baltimore 28a-f MD Halethorpe 1 🗆 Yes 2X No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be Funeral 4706 Washington Blvd. 21227 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Flower Grower Nursey 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ellen R. James Lorenz Happel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen D. Magness/ Daug. 4706 Washington Blvd., Halethorpe, MD 21227 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 11/19/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. nature of Funeral Service Licenses 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Septic Stock secondary Physician/ disease or condition Medical resulting in death) Examiner Coronary Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): and -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death g | Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate has been signed in page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 1 Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Hospital 2. No Other: 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 유 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accider
3 Suicide Accident Investigation Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Funeral Medical Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and title of certifier 29c. License number NOVEMBER, 15, 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NAWA AD A CATON BALTIMORE AVENUE 31. Date filed (Monti State Registrar

AGN 636

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 523 November DEBORAH RENEE MORTON Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death maryland Greneral HOSPITAL Baltmore N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) Hours **Director** 216-54-6825 1 🗆 M 2 🕱 F 62 SEPT. 11 1949 MARYLAND Usual Residence of Deceden 28a-f show 10b. County traumatic event, the Medical Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director 1XXYes 2 ☐ No BALTIMORE MARYLAND N/A 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3937 DUVALL AVE 21216 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify Specify: BLACK 3 Widowed 4X Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed, and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12yrs NURSE JEWISH CONVALESCENCE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked ony injury or other traumatic eve ဂ္ဂ RONALD ADDISON MARY FRANKLIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhonda Thompson/Sister 2705 Elisinore Avenue, Baltimore, Md., 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 11-29-11 OWINGS MILLS, MARYLAND 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME PA.
1206 W NORTH AVENUE 21. Signature of Juneral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Secuentially list conditions if any, leading to immediate cause. Enter Underlying Rhaaia Cause (Disease or injury and -trans that initiated events resulting in death) Last ng physician a as the burial-Physician/Medical that the death certificate be Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 month 1 Yes 2 W No Po Month Day Year 1 Yes 2 9 Unknown the 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 2  $\square$  No Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify, this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: eral Director: After filled in by the funer Natural 5 Pending 1 ☐ Yes 2 ☐ No hours after death 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) cause of death (Item, 23a) (Type, Print) Maryland Greneral Hospital UtORI

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year) - - -

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		Please Type or Prin				_	_	
		1 - State Amend Item 25 State of Mar Registrar State of Mar Per me, g9	yland/Pep; 21,11/18/ Cei	artment of F 2011dhb rtificate of L	Health and M Death			1 37065
Physicia: Medic		1. Decedent's Name (First, Middle, Last)  Vivian Demorris Miles				2. Date of Deat Month	Day Year	3. Time of Death
Examin		4a. Facility Name (if not institution, give street and number) Sina: Hospital of Baltiw	1010/		r Location of Death	4	4c. County of Dea	th
Funeral Director		5. Social Security Number 6. Sex 7. Age (	In yrs. last birthday) 8 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	g. Bir	thplace (State or Foreign
	or	Usual Residence of Decedent  10a. State 10b. County 1	0c. City, Town or Lo	cation				10d. Inside City Limits
ie Maryla r 28a-f ( notified	Director	MD N/A  10e. Street and Number	I	Baltimo	re		10- Cikings of What C	1 🔀 Yes 2 □ No
h with th ns 23a o nust be	Funeral	2401 Keyworth Ave.			21215		U.S.A.	ountry?
s after deat ral", or iten Examiner r	by	11. Marital Status  1 □ Never Married 2 □ Married  3 ▼ Widowed 4 □ Divorced  12. Was Decedent Eve Armed Forces?  1 □ Yes 2 □ Note of Yes, Give Year or Dates.		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	ispanic Origin? (Spe an, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: B]	
thin 72 hour ne. than "natu	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12) 12th Grade  College (1-4 or 5+)	(Give I	dent's Usual Occup kind of work done o O NOT use retired)	during most of worki	ng	16b. Kind of Business  Bank	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and hortial Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	a l	17. Father's Name (First, Middle, Last) Grady Melvin		1001 0pe	18. Mother's Name		Maiden Surname)	
alth and lath and z7 is m		19a. Informant's Name/Relationship (Type, Print)  Tyrone Melvin(son)	1	-			City or Town, State, Zi	o Code) , MD21204
tge 1 and nt of Hes		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, cren	osition (Name of matory or other plac	ce) [	Date	20c. Location - City or	Town, State
permit. Pa Departme Importan any injury once,		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	King Men		11/1 Figure		Baltimore uneral Ho	ome PA MD 21217
00500	- 1	23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.						Approximate
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te be exe hysician he burial	<del>-</del>	d	0110004001100 01).		CERTIFICATION APP	OVED BY MEDICA		
for the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown  IF FEMALE: 23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	Ectopic pregnand Other (specify)			23d. Date of de Month	livery Day Year
that the lned by t e detach	by Phy	Part II. Other significant conditions contributing to death but	not resulting in the u	underlying cause giv	ven in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
requires been sig should b	Completed	Hypertension				1 ☐ Ye	n 24b. Were au	robably 4 Unknown topsy findings available
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nysician nis certifi director	To Be	25. Was case referred to medical examiner?  14 Yes 2 19 No 1 19 Inpatient	t 2  ER/Outpatier	Oth	ace of Death (Checker: 4 Nursing Ho		ence 6 🗆 Other (Spec	ify)
nding Pt ath. :: After th e funeral		27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation  28a. Date of injury (Month, Day, 1)	28b. Time of fear) injury	work	y at ? Yes 2 □ No	28d. Describe ho	w injury occurred	
l or Atter after dea Director	Certificate:	3 Suicide 6 Could not be	- At home, farm, stre Specify)	eet, factory, office		28f. Location (Sti City or Town	reet and Number or Ru , State)	ral Route Number,
To the Hospital or Attending Physician: The Is within 24 hours after death.  To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Physician: To the best of my (Check 2 Medical Examiner: On the basis of example of the control of of the	mination and/or invest	stigation, in my opinio	on, death occurred at	the time, date and	d place, and due to the	cause(s) and manner stated.
To the within To the compl	Σ	only one) 3 L Certifying Nurse Practioner: To the be 29b. Signature and title of certifier	st of my knowledge, c	29c. License	e number		9d. Date signed (Monta	h, Day, Year)
		30. Name and address of person who completed cause of dear	th (Item 23a) (Type, F	KES (Print)	-000		November	4,2011
-01-1		YUKI; Elliott, MD Si 31. Date filed (Month, Day, Year) 32. Registrar's	th (Item 23a) (Type, F	tal of B	altimore			
Stat Registra		NOV 1 8 2017 Angel	p. par				·	

Examiner Box 68760. P.O. Division of Vital Records,

Hospital or Attending

law requires that the death certificate be executed attending physician for use as the buria signed by the a page 2 certificate director, this funeral After within 24 hours after death

To the Funeral Director:
completely filled in by the

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

Examiner

Physician/Medical

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Completed

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Medical Certification: To

29a. Certifier (Check only

29b. Signature and title of certifier

**Funeral** 

Director

nd other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

10

Hygiene.

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f Health and Mental Ham 27 is mark

permit. Pages 1 and Department of Healt Important: if item 27 any injury or other t

**Physician** 

/Medical

sician and burial-transit

72 hours after

Baltimore, Maryland 21215-0036

State Registrar

29c. License number RES-000

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GOO North Wolfe St, Baltimore, MD, 21287 Sophie Wells

31. Date filed (Month, Day, Year, 1 8 2011

32. Registrar's Signature

MP

Restaurant

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 230 mitchell John Novembe Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimere Bakhmore Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foleig 8. Date of Birth **Funeral** Months Hours Min (Month, Day, Year) Director Yrs. 10b. County 10a. State notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 No timore Street and Number ö 10g. Citizen of What Country? must be r by Funeral ral", or items ? Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry Hygiene. ndary (0-12) College (1-4 or 5+) alth and Mental Hygien 27 is marked other tl r traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ 19b. Mailing Address (Street and Number Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau **人心 2123 9** Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory ■ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dishock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit CERTIFICATION APPROVED BY MEDICAL EXM Due to (or as a consequence of): resulting in death) Last Physician/Medical するタイナー イルストン アルシ アルシ Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ been signed by the atter should be detached for in the past 12 months?
1 Yes 2 No Day 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform after death.

Director: After this certificate 1 Yes 2 No \_\_ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 X Yes 1 Inpatient 2 R/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28th Time of 28c. Injury at work? 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 No Accident Investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check з 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Yaar) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month 3:00 P M 2011 Rosa Isabel Molina November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hosptial 8. Date of Birth (Month, Day, Yea March 19 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours 1 🗆 M 2 🖫 F El Salvador Director 85 218-15-0349 Usual Residence of Decedent shov 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene.
Important If item 27: is marked there than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Gaithersburg MD Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20877 United States 8308 McCullough Lane #104 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1X Yes 2 □ No Specify:Salvadorian Maryland 21215-0036 Specify: White 3 🕅 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeper Nursing Facility Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Cea Molina Susana Cervando 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8308 McCullough Lane #104, Gaithersburg, MD 20877 Mario Palma / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Chesapeake Crematory 11/15/2011 1 Burial 2XXCremation 3 Removal from State Beltsville, MD 4 Donation 5 Other (Specify) 21. Signatury of Funer & Survice Livensee MO1539 Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicani RESPIRATORY FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** MULTILOBAR PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami CHRONIC ASPIRATION and -trans MEDICAL EXAM Due to (or as a consequence of): resulting in death) Last WAPPROVEDBY burialattending physician for use as the burial Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Division of Vital Records, P.O. Box in the past 12 months?

1 Yes 2 X No Month Day Year Pregnant at time of death After this certificate has been signed by the funeral director, page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 Unknown MALNUTRITIAN 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 24 No death? Hospital or Attending Physician; The Director: After this certificate 2 No 1 🗌 Yes 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🗓 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At completed filled in by the fu death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical XX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated for third place. To the cause of the cause of the time death occurred at the time, date and place, and the cause of the ca 29b. Signature and title of q 29c. License number 29d. Date signed (Month, Day, Year) NOVEMBER 11, 2011 D63343 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IRINA YURYEVNA RUBAN M.D., 1500 FOREST GLEN RD., SILVER SPRING, MD 20910

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

NOV 1

32. Registrar's Signature

State Registrar York Road

Lutherville

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

no

Mar I. Leavey

NOV 2 1 2011

31. Date filed (Month, Day, Year)

1734

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1:40 A. M Marv Norton November 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c, County of Death Stella Maris Timonium **Baltimore** Social Security Number 7. Age (In vrs. last birthday If Under **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country)
Maryland (Month, Day, 1 □ M 2X F Months Davs Hours Year) 923 Director 218-14-5434 88 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 Yes 2 X No Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2300 Dulaney Valley Road 21093 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give 1 X Never Married 2 Married þ 21215-0036 1 ☐ Yes 2 🎇 No Specify: 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Office Manager Furniture Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frank Norton Marv Starr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (GrNephew) Ernest J. Ketcham 6133 North Hull Drive Kansas City, Missouri 64151 permit, Page 1 and 3 Department of Healt Important; If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-29-11 Druid Ridge Cemetery Pikesville, Maryland 21. Signature of Funeral Service Licenses Mitchell-Wiedefeld Funeral Home, Penane 6500 York Road Baltimore, 23a. Part 10 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ neumonic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 🗷 No Year Pregnant at time of death Unknown Dav g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 20 No Yes 1 Typs Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending X Natural injury 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 2 2011 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) 2300 DULANEY VALLEY ROAD ERNESTINE WRIGHT, M.D.TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

:40

NORTON

DOROTHY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Nauman Vr. John 04:40AM November 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Da Himore **Examiner** Genesis Multimedical Center Towson Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 213-32-1677 1**XX** M 2 □ F Days Hours Min 78 04/24/1933 Director Mary Land Usual Residence of Decedent Show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f s notified 1 Yes 2XX No Maryland 1 Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ural", or items 23a of Examiner must be Funeral 905 01d 0ak Road 21212 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1XX Yes 2 \( \subseteq \text{No.1962} \) Black, White, etc. 1 Never Married 2XX Married Completed by Maryland 21215-0036 1 ☐ Yes 2 XX No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of thealth and Mental Hyglene. Important If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Engineer Utility Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ William John Nauman Sm Sarah Frances Conroy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Louise Nauman Wife 905 Old Oak Road Baltimore, Maryland 21212 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1XX Burial 2 Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Gardens 11/21/2011 Timonium, Maryland nature of Funeral 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the discase, or con shock, or heart failure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Glioblastoma Physician/ Multiforme disease or condition resulting in death) 6months-142A Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any heading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Dire to (or as a consequence of): Exami been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has autopsy performed 2 No Yes 1 Yes Be 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) examiner?
1 Yes Other: 2 1 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending work Accident
Suicide Investigation 1 Yes 2 No 24 hours after deatl 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifie 29c. License number R097104 npleted cause of death (Item 23a) (Type, Print) 10 P Genesis Multimedical Center 7700 York Rd. Towson, MD 21204

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ APAFOTIS 7:30 AM ELMA NOVEMBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE IOLNA If Under 1 Year If Under Date of billing 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔽 8 3 Months **Director** MOIANA Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at **Funeral Director** 28a-f 1 ☑ Yes 2 ☐ No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 No 2 🖪 No 1 Yes Specify White 3 Widowed 4 Divorced Year or Dates ed other than "natu event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F မ other traumatic and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .8 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of h Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 21333 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ choda disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death 1 Yes 2 9 Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perforn 2 N 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death e Hospital or Attending P 124 hours after death. e Funeral Director; After t Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending 2 🗌 No 1 Yes Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital or within 24 hours a To the Funeral D Medical 29a. Certifier 🚇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) le MI). 801 Williams State

Registrar
DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Mosh Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City**  Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) Funeral Months Hours (Month, Day, Year) Dec 16, 1943 MD 67 214-40-3640 Director 1 M 2 D F Usual Residence of Decedent 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location should be filed within 72 hours after death with the Maryland and Mental Hyglene.

is marked other than "natural", or items 23a or 28a-f shov 10a. State Director must be notified Columbia Howard MD 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 21044 U.S.A. 10388 Launcelot Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 1 No Black, White, etc. 1 Never Married 2 M Married à Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify. Yes Give Specify. 3 Widowed 4 Divorced Completed event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed, Elementary/Secondary (0-12) College (1-4 or 5+) Vetrinarian Supplier **Territorial Manager** 5+ Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Minnie Feaser Herbert Francis Quail other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health an Important: If item 27 is any injury or other trau 10388 Launcelot Lane Columbia, MD 21044 Henriellen Quail spouse 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State Nov 16, 2011 Glen Burnie, MD Atlantic Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 Signature of Funeral Service Licenses HE ROVED BY MEDICAL EXAMINA or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a Approximate Interval Between Onset and Death 23a. Part 1. Part 1. Enter the disease, or complications that caused shock, or heart failure List only one cause on each line Immediate Cause (Final Medical Aspiration Sorium disease or condition resulting in death) CERTIFICATIO Due to (or as a consequence of Examiner phog Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury bureus Carciroma Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi s been signed by the attending physician and should be detached for use as the burial-tran that initiated events for as a consequence of resulting in death) Last Due to by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has director, page 2 autopsy performed' this certificate Yes 2 ☐ No 1 Yes 2 No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examine? Hospital: 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA ျ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After □ Natural 5 Pending 900 M Berium Aspiration Accident Investigation filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Ryral Route Number-City or Town, State) 22 ~ CACA ) 4 Homicide determined Mary and Med 01 Cente VINERSIR Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Toletely Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the ! within 2 To the F only one 29b. Signature and title of certifie Bond MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Michael
31. Date filed (Mc

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MD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh g921 11-21-11 vt
State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nov 20:03 201<sup>Year</sup> Herbert John Reichert III 17 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Carroll Westminster If Under 1 Year If Under 24 Hrs. 5. Social Security Number Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1**X** M 2 □ F Months Hours Min. (Month, Day, Year) 10-11-1943 Country) 68 Director 217<del>-44</del>-5803 MĎ Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD Carroll New Windsor 1 Yes 2 No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 1698 Hoke Rd. 21776 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: Specifywhite "natural", Completed 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Auto Body Painter 9 Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event one. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Herbert Reichert Sr. Gertrude Zeblein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Reichert-wife 1698 Hoke Rd., New Windsor, MD 21776 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial 11-22-11 Sykesville, MD Signature Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home Honas 21157 54 Ε. Main St., Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician BRILLATION ENTRICULAR disease or condition Due to (or as a consequence of): Medical resulting in death) Examiner sclaratio card Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events the burial-transi attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) Pregnant at time of death Unknown page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performe death? 2 7 2 No Yes 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, Be 26. Place of Death (Check only one) Hospital: Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred work? injury Natural 5 Pending 2 \ No Accident Investigation 24 hours after death Funeral Director: the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined Medical 🖭 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Witigelish No 18200 11-18-11 pode Rd. WESTMINSTERHD 21157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NACIANNA MD 700 A CHITIACITEDY 31. Date filed (Month, Day, Year) 32. Re trar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ที่วี<sup>เท</sup>ี/10/2011 5:50 PM <u>Harold J. Russell</u> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Summitt Park Nursing Home Catonsville Baltimore Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1 ★ M 2 □ F Months Hours Min Director 80 <u>21</u>2-26-7069 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director MD Baltimore Catonsville 1 Yes 2 XNo 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a 1502 Frederick Road 21228 USA "natural", or items within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Specify: White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Milkman 10 Dairy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Adelbert Russell Etta Elliott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 sl Health a If item 27 John H. Gondeck / Nephew 8543 Legion Road, Denton, Maryland 21629 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Page 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 11/16/2011 | Baltimore, Maryland Donation 5 Other (Specify) ature of Funeral Service Licensee Sia 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ de disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death signed by the aid be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 autopsy death? certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifies 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) P 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ¥ \_\_\_\_\_\_Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21229 State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 20<sup>ay</sup> Month 5:127 M Robert F. Sandosky 20**T** Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Carroll Sykesville Fairhaven Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9 Birthplace (State or Foreign **Funeral** 1 **X**M 2 □ F Hours 215-32-3578 76 1934 Director Usual Residence of Decedent 10b. County filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10a State 10c City Town or Location 10d. Inside City Limits Director 1 Yes 2 No Carroll Sykesville Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21784 USA 7200 3rd Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Analyst-Ft. Meade permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other to any injury or other traumatic event, the once. Computer Analyst 4Yrs. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lillian Weetenkamp Louis Sandosky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 West Church St. Smithville, Tn. 37166. Sandosky (Executor) Fave 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State All County Cremation 11/22/2011 Sykesville, Md. 4 Donation 5 Other (Specify) 21. Signature of Fune Service Licens 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md. 21784. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nset and Death Immediate Cause (Final Physician Vancreat c disease or condition resulting in death) Geurs Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other 2 5 100 ျင 1 Inpatient 2 ER/Outpatient 3 DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State Example 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title 734849 30, Name and address of person who completed cause of death (Item 23a) (Type, Prin

Registrar
DHMH 17 Rev 7/2009

State

MD

31. Date filed (Month, Day, Year)

1645

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Ruth Lang Smith 18, 2011 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Roland Park Place Baltimore N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 8. Date of Birth | (Month, Day, Year, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 😾 F 96 1914 510-52-1611 16, Director Dec. Kansas Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 √ Yes 2 □ No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or dical Examiner must be r 830 W. 40th. Street 21211 U.S.A. 14. Race - American Indian, Black, White, etc. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If fem 27 Is marked other than "natural", or Itee in yor other traumafte event, the Medical Examine Iny or other traumafte event, the Medical Examine 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 years Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Henrietta Wyley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norman Lang Smith (son) 1742 Hillside Road Stevenson, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of Important: If it any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 11-21-11 | Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland Mitchell-Wiedefeld Funeral 6500 York Road Baltimore 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21212 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** demenna /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the burial Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Aurtic 2 No ANLYVS M 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed pulmonar embolus 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an Û certificate has be rector, page 2 s autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After t 1 Natural 5 ☐ Pending investigation Injury I hours after death. \*\*Cuneral Director: Af ally filled in by the full. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 2 1 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

llan

35102

m.D. 5901 North CHAYLES Street Baltimore Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joseph Lewis Scott, Sr. 3:40 PM 12,2011 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Towson Baltimore Gilchrist Hospice Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours (Month, Day, Year) 212-28-6348 1 XM 2 □ F Director 79 Vrs Jan.9,1932 Maryland or 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 XYes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? USA Funeral 3202 Harford Road 21218 death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X XNo If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc þ 1 Never Married 2 Married hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: than "natural", Completed 3 X Widowed 4 Divorced Black traumatic event, the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12)
7th Grade College (1-4 or 5+) and Mental Hygiene. is marked other tha Motor Freight Warehouseman Be 7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Anna Mae Bailey William Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3202 Harford Road Baltimore, MD 21218 mit. Page 1 and 2 sh bartment of Health a bortant: If item 27 is / injury or other trai Joseph L. Scott, Jr./Son Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or oth cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
4 Donation 5 Wother (Specify) Entombment Woodlawn Cem. 11/17/11 Woodlawn, MD 21. Signature of Funeral Service Licensee Chatman-Harris Funeral 22. Name and Address of Facility 4210 Belair Road Baltimore, MD 21206 tearres 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): Phynician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death 9 I Inknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? 2 No 1 Yes 2 W 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tyes 2 146 ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. lnjury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Certificate: eral Director: After filled in by the funer (Month, Day, Year) Vatural 5 Pending M Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tile of crifier 13 71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 NCh 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 06-2011

ORIGINAL

37079

		-	State Registrar		Cer	tificate of L	Death		Reg. No.				
	Physicia	n/	1. Decedent's Name (First, Middle, La	•				2. Date of Dea		0 2011	3. Time of Death		
	Medic	al	FRED  4a. Facility Name (if not institution, give	STONE			Land Control	NOVEMB			11:49А м		
ز	Examin		HOLY CROSS HOS	SPITAL		4b. City, Town, or Location of Death SILVER SPRING  4c. County of Death MONTGOMERY							
	Funeral Director		420-36-4986	Sex   7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birt MAY 20		9. Birthp	place (State or Foreign		
р	how	2	Usual Residence of Decedent  10a. State  10b. County	10c. City,	Town or Loc	cation				1	0d. Inside City Limits		
be filed within 72 hours after death with the Maryland	, Ba-f s tiffied	ect	MD PRINCE (	GEORGE'S BU	RTONSV	ILLE					1X Yes 2 ☐ No		
	a or 2 be no	Funeral Director	10e. Street and Number	-		10f. Zip Code				n of What Cour	ntry?		
	ns 23 must	ner	3236 TAPESTRY C		1	2086			USA				
ar dea	or iter niner	by Fu	<ul> <li>11. Mantal Status</li> <li>1 ☐ Never Married 2 X Married</li> </ul>	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No	1	f Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto	Rican, etc.)	14.	. Race - Americ Black, White,	etc.		
rs afte	ıral", I Exar		3 🗆 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.	1	☐ Yes 2 🏝 No	Specify:		Spi	ecify: DI	_ACK		
2 hou	"natu edica	plet	15. Decedent's I (Specify only highest g		(Give I	lent's Usual Occup	ation during most of work	ing	16b. Kind	of Business Inc	dustry		
ithin 7	ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)		O NOT use retired) <b>ENANCE</b>			PRIVATE				
	l Hyg l othe vent,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	, , ,	Maiden Sur	rname)			
d be	Menta larked atic e	입	WILLIS STONE		1		ANNIE	GREER					
Shou	h and 7 is m traum		19a. Informant's Name/Relationship				and Number or Run		•	· ·			
and C	Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the Nonce.		MARY STONE/WIF	20b. Pla	ace of Dispo	sition (Name of	CIRCLE I	Date Date		tion - City or To			
2age 1			1 ☐KBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	_ nemoval nom state		natory or other place	i i	2/2011	TATE	REL,MARY	ZT.AND		
armit.	Departm Importa any inju once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME, INC.										
ם נ	.o⊆āā , ,i.: Medical		Dayshney N.	brnelillo			OVER ROAI			E,MARYLA			
1000			23a. Part 1. Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition ACUTE MYOCARDIAL INFARCTION  ACUTE MYOCARDIAL INFARCTION										
			disease or condition resulting in death)	a. ACUTE MYOC		L INFARC	CION						
~- E	xaminer	L	Sequentially list conditions,	ATHEROSCLE		VASCULA	R DISEASE						
D	ysician and e burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):								
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ath ce	attendin for use	Physician/	23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No	23c. If yes, outcome of pregnan  1  Live Birth 2 Fetal  4  Pregnant at time of de	death 3	Ectopic pregnand Other (specify)	су		236	<li>d. Date of deliv Month</li>	ery Day Year		
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Physi	r this c	일::	1 ☐ Yes 2X No 27. Manner of Death	1 Inpatient 2 tx	ER/Outpatier 28b. Time of	nt 3 🗆 DOA	4	ome 5 Resi			/)		
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or Atte	after de <b>Directo</b> I in by tf	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined			eet, factory, office	7	28f. Location ( City or Tov		lumber or Rura	l Route Number,		
Hospital	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendir completed filled in by the funeral director, page 2 should be detached for use	Medical	(Check 2 Medical Exam	ysician: To the best of my knowle niner: On the basis of examination	and/or inves	tigation, in my opini	on, death occurred a	at the time, date a	and place, ar	nd due to the ca	use(s) and manner stated		
othe	vithin 2 of the comple	ž	only one) 3 Certifying Nu 29b. Signature and title of certifier	rse Practioner: To the best of my	knowledge,	death occurred at the 29c. Licens		ce, and due to th		nd manner as st signed (Month,			
	> - 0		1 Tomats 1	"MIlla-	MD	D	39532	_		MBER 17			
			30. Name and address of person who			Print)							
	Cla	10	TIMOTHY P. MCCLA 31. Date filed (Month, Day, Year)	IN M.D. 9971 GO	ORMAN ure	AVENUE L	AUREL, MA	RYLAND	20723				
	Sta Registr		NOV 2 1 2011	32. Registrar's Signatu	MOUN								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 25 per me, g922, 12/05/2011dhb Certificate of Death Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month Day Year **Physician** 2343 PM nenneth 2011 November 14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days 47 Maryland Director 212-88-6629 June 18, 1964 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1) Yes 2 □ No Director Maryland Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? USA 21224 241 S. Bouldin Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces Black, White, etc. 1 Yes If Yes, Give 1 Never Married 2 Married 2**X** No Baltimore, Maryland 21215-0036 Specify 1 ☐ Yes 2 😿 No à Specify: White 3 Widowed 4 Divorced Year or Dates "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education other than "natu (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Produce Manager Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Eleanor Precht Joseph R. Scheufele, Sr. ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trau 1773 Inverness Avenue, Dundalk, Maryland 21222 Skye Scheufele - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/19/2011 | Glen Burnie, Maryland Atlantic Crematory 22. Name and Address of Facility Gary L. Kaufman F.H. @ MMP 21. Signature of Funeral Service Licen 7250 Washington Blvd., Elkridge, MD M01283 or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the discusses shock, or heart failure. I Approximate Interval Between Onset and Death Immediate Cause (Find Multi--organ Due to (or as a construence of): **Physician** disease or condition resulting in death) /Medical Examiner povolemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY HEDICAL EXAMINER Examine or Attending Physiclan: The law requires that the death certificate be executed MESIS attending physician and I for use as the burial-tran Due to (or as a consequence of) トンメートン インソソレト Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death Live birth 3 - Ectopic pregnancy Month Day Year 5 Other (specify) Yes 2 🗌 No by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Hinknown ependence 1 Yes completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 1 Tes 2 □ No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 XYes 2 2 ER/Outpatient 3 DOA ၉ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No 2 Accident within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 🔲 Suicide 4 - Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) ind manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatur 29c. License number 11-15-2011

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of

31. Date filed (Month, Day, Year)

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npleted cause of eath (Item 23a) (Type, Print)

sal

32. Registrar's Signature

-000

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland Department of Health and Mental Hygiene Registrar

23a,25 per me,g921,117,187,201,14hb 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Kegina Smith 9:25p M october 30 1105 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randallstown Baltimore Season's Hospice 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours (Month, Day, Year) **Director** 216-62-0607 Usual Residence of Decedent 59 1 M 2 X E Yrs 52 04 03 MDpermit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if filen 27 is marked other than "natural", or items 29 content in the Maryland any injury or other traumatic event, the Maryland once. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director 1 XYes 2 No Baltimore MD NA 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 21225 2702 Woodview Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 XNo If Yes, Give Black 1 Yes 2 X No Specify Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) State of Maryland Specialist 2th grade Employment  $4 {
m vrs}$ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Hazel Knotts Fred Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2702 Woodview Road, Baltimore, Md 21225 Robert Nailor Sr-Husband 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Garrison Forest 1 XBurial 2 Cremation 3 Removal from State 11/4/2011 Owings Mills, Md 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between mediate Cause (Final Onset and Death Physician/ Intracerebral Hemorrhome disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner rany, reading to immediate cause. Enter Underlying Cause (Disease or injury Duc to (or as a sonsequence of, OFFITIFICATION APPROVED BY MEDIT attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Pregnant at time of death been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cocaine Use 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available 24a. Was an s certificate has b director, page 2 s prior to completion of cause of death? performed?

Yes 2 No 1 🗌 Yes 2 🗆 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 4 Nursing Home 5 Residence 6 Other (Specify) examiner?
1 XYes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No Investigation 6 Could not be ☐ Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifier nskajapalmol M.D 00057465 10 31/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21709. 5 203 Ray apakse MID: 2835 Smith N N.5 31. Date filed (Marth V

DHMH 17 Rev 06-2011

State Registrar Registrar's Signature

8

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November Pay 19 2011 James Α. Schepf Sr. Medical 01:13 AM 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Pear Tree Assisted Living Pasadena Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 218- 16- 1845 Months **Director** 1 🛛 M 2 🗆 F Yrs. 87 Oct. 31 1924 MD Usual Residence of Decedent 28a-f show 10b. County Director 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified Maryland Anne Arundel Linthicum 1 🗌 Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 556 Cleveland Road 21090 **HSA** Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? ō þ 1 Never Married 2 Married Black, White, etc. Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: 3 X Widowed 4 Divorced Completed Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Secondary (0-12) International College (1-4 or 5+) Warehouseman Harvester Be 17. Father's Name (First, Middle, Last) and Mental Fishers is marked of 18. Mother's Name (First, Middle, Maiden Surname) ၉ and 2 should be John Schepf Agusta Flock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a James A Schepf (son) 8119 Buttercup Lane East, Pasadena, MD 21122 Baltimore, 20a. Method of Disposition Department of h Important: If ite 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State any injury or Nov. 4 Donation 5 Other (Specify) Meadowridge, Cemetery Elkridge, Maryland 2011 Signature of Funeral So vice Ligense 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complishock, or heart failure. List only one ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 23d. Date of delivery ó in the past 12 months? 1 Yes 2 No Pregnant at time of death ed by the a detached f Day 1 Yes 2 9 Unknown Month P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? should be of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed Yes 2 2 (1) 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ၉ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death After 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred the Hospital or Attending Natural 5 Pending Division death. 1 🗌 Yes filled in by the Accident Investigation 2 No Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

10 BW

State Registrar

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31. Date filed (Month, Day, Year) 32 Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25 per verb., g921,11/21/11dhb

Certificate of Death

Reg. No. For A State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death SMI Physician/ Month 130A 2011 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death
Baltime Examiner 4c. County of Death Son (SVW If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** M 2 🗆 Days Hours Months Min. u Tyonth Bay, Yel 944 6 Matyland 215-42-1459 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Baltimore 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? ō 10f. Zip Code Funeral 23a 2525 Eutaw Place; Apt 511 21217 USA items ? unk 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 No 1960-Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 black. 1 ☐ Yes 2 🗓 No Specify: "natural", Specify: 3 Widowed 4 Divorced 1963 Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 hand Mental Hygiene.
7 is marked other than "n (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) bus driver transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrew Stanton Smith Veronica Ceclia Samuels and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry Smith - brother 2525 Eutaw Place; Apt 511; Baltimore, MD 21217 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 or other 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) ture Uneral Service Ronal 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest of heart failure. List only one complete on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical as the l attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 🗀 Fetal death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death 5 Other (specify) the page 2 should be detached 9 Unknown P.O. ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Onknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 10 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 1 1 Natural (Month, Day, Year) 5 Pending work? within 24 hours after death.

To the Funeral Director: Al
completed filled in by the fu 1 Yes 2 No Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tine of certifier 30. Name and address of person who completed cause of death (Item 32. Registrar Signatur State

DHMH 17 Rev 7/2009

Registrar

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Colleen Joy Steffan State of Maryland / Department of Health and Mental Hygiene 2011 37084 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 14, 2011 Medical Examiner 1240 hrs Colleen Joy Steffan 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Calvert 325 Banister Court Lusby 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Director 264-55-1993 Country) N.J. 1 M 2**X** F 52 08/07/1959 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 Yes 2 X No Calvert Co. Lusby hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 325 Bannister Ct. 20657 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2K No Yes 3 Widowed If Yes, Give Year Specify: White 4 Divorced 1 Yes 2 No specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 Baltimore, MD 21215-003 Nurse Shellpoint 2 years of Health and Mental Hygiene. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Ronald Smith Arlean Biedell ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t: If item 27 is Thomas Steffan(son) 2202 Waltham St., Pensacola, FL 32505 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State on-site Crematory 16/11 4 Donation 5 Other Specify: Baltimore, 21 Signature of Funeral Service Licenses 30sephod Fish own JR. Funeral Home PA 2140 N. Fulton Ave., Baltimore MD21217 Approximate Interval Between Onset and 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line /Medical Death Immediate Cause (Final disease a Ethanol and tramadol intoxication complicated by drowning ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED 23a, 27, 28a-f, per me, g922 12-6-11 sm M UNPENDED The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 1 Live birth 2 Fetal death Month Day Year past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown 9 Unknown the Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š σ, 1 Yes 2 No 3 Probably 4 V Unknown Completed Records. 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of 125 death? performed? certificate ✓ Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other Scene this 1 🗸 Yes After 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: Division 1 Natural 1 Yes 2 X No 5 Pending unknown I Director: d in by the f death. fd 11-14-11 fd 12:40 pm 2 \_\_\_ Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 X Could not be or Town, State) 325 Banister Ct. (Specify) found at home Homicide Lusby, Md. 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 😿 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 15, 2011 Samuel 200 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signature State Parks Registrar

**OCME** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month NOV Rosalind Caldwell Thomas 10 20 1 1 12:05 pM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Towson Gilchrist Hospice Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) ocial Security Number 7. Age (In yrs. last birthday) **Funeral** 220-50-0153 Days Director 1 🗆 M 2 🌠 F 62 Nov. 18, 1948 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No N/A MD Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21286 1545 Doxbury Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Eyer in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 7 Married Yes Maryland 21215-0036 72 hours after 1 Yes 2 1 No Specify: If Yes, Give Specify: Black "natural", 3 ☐ Widowed 4 M Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Blue Cross and and Mental Hygiene. is marked other than life DO NOT use retired) Elementary/Secondary (0-12) Blue Shield of MD. Billing Supervisor Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Crawford Caldwell Elizabeth Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Frazier - Daughter 1545 Doxbury Road Towson, Maryland 21286 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 11/16/2011 Glen Burnie, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Road Baltimore, Maryland 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final thysician/ Dancreatic disease or condition resulting in death) menty Medical ue to (or as a consequence of) Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of). sician and burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Records, P.O. Box 68760 phys the as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 ☐ Yes 2 No Month Year Day Pregnant at time of death 9 Unknown 9 Unknown þ Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed 1 Yes 2 No Yes 2 X No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles ST TOWSON MO MALIES W

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 23aPtI,28a-f per me, 2921,111/18/2011dhb
Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ESILE THORNBURG NOVEMBER 89 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center Baltimore BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/21/1954 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours Min. 1 🗆 M 2 🕱 F 333-42-6241 57 GA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show other traumatic event, the Medical Examiner must be notified at 1 Yes 2XXNo Director 28a-f Frederick Mt. Airy 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number items 23a 901 S. Warfield Dr. 21771 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White than "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) School Teacher/Librarian Virginia School System and Mental Hygie Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold D. Thornburg Margaret C. Cochran ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Harold Thornburg/Father 901 S. Warfield Dr., Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 Important: If it any injury or c 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pine Grove Cemetery 11/15/2011 Mt. Airy, MD 21. Signatur o Funeral Service Licensee 22. Name and Address of Facility.
Burrier-Queen Funeral Home & Crematory. P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death a Sto / Total Body Stufface

Due to (or as a conse place of): | Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events nding physician and use as the burial-transit resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? 4 Pregnant at time of death 1 Yes 2 No 5 Other (specify) completely filled in by the funeral director, page 2 should be detached 9 Unknown the Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ş 2 No 3 Probably 4 Unknown 1 Tyes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ✓ Yes 2 ☐ No Hospital: Inpatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 2 ER/Outpatient 3 DOA မ 28a. Date of Injury
"fanth Day Year) 27. Manner of Death 28c. Injury at Work? 28h Time of 28d. Describe how injury occurred Certification: 3:27 p After 1 Natural Subject doused self with or Attending 5 Pending investigation 11/08/2011 M 1 Tes 2 X No death. 2 ☐ Aecident 3 ☐ Suicide flammable liquid and ignited
28f. Location (Street and Number or Rural Route Numbe Self.
City or Town, State) 901 S. Warfield Dr., after death 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Yard Mt. Airy, MD e Funeral D Hospital 29a. Certifier Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the vithin 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES-000 November 9, 2011 0 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) FOSSUO 4940 Eastern Avenue, Baltimore, MD, 21224 Registrar's Signatur State

**ORIGINAL** 

DHMH 17 Rev 1/2001

Registrar

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	Physicia	n/	1. Decedent's Name (First, Middle, La	ŕ	COM			2. Date of Death Month November	Day 18	2011	3. Time of Death
	Medic Examin	al	The Library of Dotte								
المر			728 213th Stree		to at his the day.		sadena If Under 24 Hrs.	8, Date of Birth	An		rundel  pplace (State or Foreign
	Funeral Director		,	Sex 7. Age (In 1 ☐ M 2 X F	yrs. last birthday)		Hours Min.	(Month, Day, Y	ear) 1931		ntry) WV
	how at	۱	Usual Residence of Decedent  10a. State  10b. County	10-	c. City, Town or Loc	cation		riay 27			10d. Inside City Limits
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	h the N Sa or 2 be no	al Di	10e. Street and Number			10f. Zip Code	21122	10	g. Citizen of	What Cou US	
	eath wit	Funeral	728 213th Stree	12. Was Decedent Ever	in U.S. 13. V	Vas Decedent of Hisp	panic Origin? (Spe	ecify Yes or No-		ce - Amer	ican Indian,
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mertal Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates.		f Yes, specify Cuban,  ☐ Yes 2 🖾 No		Hican, etc.)	Specify	ck, White	, etc. White
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pu	e filed ital Hyged oth event	To Be	17. Father's Name (First, Middle, Las	Tribett			18. Mother's Name Goldie	e (First, Middle, Ma	<sub>iden Surnar</sub> kinsor		
Maryland	hould by and Mer s mark umatic		Delmar A.  19a. Informant's Name/Relationship	(Type, Print)		ng Address (Street an	d Number or Rura	al Route Number, C	lity or Town,	State, Zip	Code)
Ž,	und 2 si lealth a mm 27 i her tra		Frank G. Tracey,			213th Str	1	D-1- 2	D ZIIZ  Oc. Location		Town State
Baltimore,	Page 1 anent of H ant: If ite ury or ot		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from State		natory or other place) en Cemeter	Nov.	011 G	len Bu	ırnie	e, Maryland
Balt	permit. Departi Import any inji		21. Signature of Funeral Principles	タル	_		ıntain Ro	oad, Pasa	dena,		Home, P.A.
ī			23a. Part I. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final	omplications that caused the y one cause on each line.	e death. Do not ente	er the mode of dying,	such as cardiac o	or respiratory arres	t,		Approximate Interval Between Onset and Beath
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Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome of p 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tin g ☐ Unknown				ate of del Ionth	ivery Day Year		
P.O.	s that the gned by the detache	by Phy	9 Unknown  Part II. Other significant conditions	_	the cause of death?						
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visio	or Attencentifier death	Certificate:	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	ot be 28e Place of Injuny		M 1 Ves 2 No  et, factory, office  28f. Location (Street and City or Town, State)			lumber or Rural Route Number,		
Ξ	Hospital 24 hours a Funeral I	Medical	(Charle 2 Modical Ev	Physician: To the best of my aminer: On the basis of exan	mination and/or inves	stigation in my opinion	<ol> <li>death occurred a</li> </ol>	at the time, date and	place, and c	lue to the	cause(s) and manner stated.
	To the within 2 To the I	Ň	only one) 3 Certifying 1 29b. Signature and the of certifier	Nurse Practitioner: To the be	est of my knowledge	e, death occurred at the			d. Date sign		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEMBER Day 1 1 , 2011 5:10 a<sup>M</sup> ULPIANO TRINIDAD-JIMENEZ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death JOSEPH RITCHEY HOUSE BALTIMORE N/A Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Hours DOMÍNICAN REPUBLIC 584-42-0681 **Director** 1 🗶 M 2 🗆 F JUNE 3,1936 75 Usual Residence of Decedent 28a-f show aţ 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director notified 1 🏋 Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be items 23a Funeral 2826 MAUDLIN AVENUE 21230 U.S.A. Was Deceud... Armed Forces? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 X Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Y Yes 2 No Specify DOMINICAN Completed 3 Widowed 4 Divorced Specify: WHITE Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) the ELECTRICIAN CONSTRUCTION is marked other permit. Page 1 and 2 should be fileo
Department of Health and Mental Hy,
Important; If item 27 is markany injury or other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ NICOLAS TRINIDAD CATALINA JIMENEZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARIA ALMANZAR/ WIFE 2826 MAUDLIN AVENUE, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State TRINITY CEMETERY 11/14/2011 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses T EASTERN AVENUE, BUNERAL HOME BALTIMORE, MD 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician end-stage disease or condition Medical resulting in death) **Examiner** Sequentially list nonditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical death certificate be as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Pregnant at time of death 2 No 9 Unknown 9 Unknown The law requires that the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Vital director. 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Tyes ٩ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After Natural 5 Pending injury work? 1 \(\sime\) Yes Division 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check Curtifying Nume Practitioner: To the best of my knowled 29b. Signature and title of certific 29d. Date signed (Month, Day, Year, Name and address of person who completed cause of death (Item 23a) (Type, Print) 828 N. Eutaw St. Baitimore, MD 21201 amille Menino State Registrar

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1 - State Amend Item 24a pr verb., g921, 11/21/2011 dhb
Registrar Registrar Registrar Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12, 2011 10:40 Michael Lee Thompson November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Ritchie Hospice **Baltimore** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth May 10, 1950 9. Birthplace (State or Foreign **Funeral** California **Director** 571-86-1867
Usual Residence of Decedent 1 XM 2 □ F 61 Yrs show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 3415 W. Forest Park Avenue 21216 **USA**  Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White "natural" Completed 3 Widowed 4 X Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the unk unk laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk and Mental Fis marked o ျ Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evence, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $3011\ \ Dunglow\ \ Rd;\ \ Balto,\ \ MD\ \ 21222$ Herb Aney - friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) In state 22 Name and Address of Facility State Anatomy Board uneral Director 655 W. Baltimore St; Baltimore, MD 21201 Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ Non-small disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or): the burial-transi Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autope performed: 2 🗆 No 1 Yes Thempson, 1 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence To the Hospital or Attending Physiwithin 24 hours after death.

To the Funeral Director, After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State within 24 hours a

To the Funeral I

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

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of death (Item 23a) (Type, Print)

29c. License number

O.C.M.E.

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

November 14, 2011

State Registrar

To the

2 🗸

29b. Signature and title of certifie

Theodore M. King, Jr., MD.

and manner stated

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Wilson Mary Elizabeth 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Baltimore Union Memorial Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) 246-38-4827 **Director** 1 □ M 2**X** F 81 Yrs June 30 1930 NC or 28a-f show notified at death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Westminster 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ritems 23a or ner must be r Funeral 1613 Valley Drive 21157 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes \_2 XNo Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 ▼ No Specify: 3 X Widowed 4 □ Divorced Specify: white Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) LPN health care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပု Tessie Capps Amos Caulifer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Randy Wilson (son) 1613 Valley Dr., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial 11-23-11 Sykesville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel Signature of Funeral Service Licensee P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause un each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregrant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 mo Month Day Year Pregnant at time of death be detached 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has page 2 s autopsy performed Yes 2 2 No filled in by the funeral director, 25. Was case referred to dica Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 잍 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne Death 28b. Time of injury Certificate: 28c, Injury at 28d. Describe how injury occurred 5 Pending Natural work' 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4  $\square$  Homicide determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ,2011 5.05 AM Wong Chung Tong N /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard Lorien Columbia Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 28, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 □ F Yrs. 91 Nov. 212-92-1318 China Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State d other than "natural", or Items 23a or 28a-f show event, I'm Madical Evol, The cust by Talilliad at 1 XYes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3913 Brehms Lane 21213 Funeral <u>U.S.A.</u> within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 1 No Specify: þ Specify: Chinese 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "any Injury or other traumatic event, I'm Meance. Elementary/Secondary (0-12) College (1-4or 5+) Chef Restaurant 6 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wah Dao Wong Chee ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rockville, Maryland Kwan Wai Wong 14102 Calabash Lane (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Grdns. 11-23-11 Timonium, Maryland 21. Signature of Funeral Service Licensee Mitchell-Wiedefeld Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6500 York Road Baltimore, Maryland Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEU M.NIA FEW DAYS **Physician F**edical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and しいかん こ ナンル ら Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 □Yes 2 No e Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifies 10062634 21, 2:11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar MATEEN

31. Date filed (Month, Day, Year) NOV 2 1 2011

HICK.RYRIDE RO

CILUMBIA MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37093 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 19, 2011 Hilda Marie Wilson 3:35 P.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Westminster Carrol1 Brightview Westminster Ridge If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day Y 1 □ M 2 🐺 Year 1919 Months Days Hours 92 Maryland Director 215-07-5731 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Carroll Finksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21048 U.S.A. 1604 Walter Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, r than "natural", or ite the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify. If Yes, Give Year or Dates "natural" 3 XWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) 12th College (1-4 or 5+) Homemaker Own Home 12 should be filed wit alth and Mental Hygie 27 is marked other ir traumatic event, <u>ti</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Christian Schmitt Martha Klotzbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tran 2305 Pheasant Run Dr., Finksburg, MD 21048 Joanne E. Sayre (Daughter) 20a. Method of Disposition
1 → Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11/23/11 Evergreen Mem'l Grdn\$ Finksburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. Bd 11605 Reisterstown Rd., Owings Mills, MD 21117 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Roysician/ Medical mier (0100 disease or condition resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 2 No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSIRA YWO 2 No ပ ER/Outpatient 3 DOA 1 Inpatient 2 I 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After t ☐ Matural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Priyadian. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

on Apel no 31. Date filed (Month, Day, Year)

NOV 2

20059943

29d. Date signed (Month, Day, Year)

10vember 21,2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 Year May Elizabeth White Nov 20 5:00 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Carroll Carroll Hospice Dove House Westminster Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 MD **Funeral** 1 M 2 XF Days (Month, Day, Year) 0-5-1926 219-20-4050 85 **Director** Usual Residence of Decedent 28a-f show 10a. State notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Carroll Finksburg 1 Yes 2 XNo 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral 1941 Brown Rd. 21048 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify 3 Divorced 4 Divorced Specify: white "natural" Completed 16a. Decedent's Usual Occupation

The wind of work done during most of working the Medical 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Homemaker Housewife 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harvey C. Mann Elizabeth Flynn traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis White-husband 1941 Brown Rd., Finksburg, MD 21048 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of F Important: If ite any injury or ot once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Sandymount Cem. 11-23-11 Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) of funeral Service Licenses 22. Name and Address of Facility Fletcher Funeral Home homas ashlu-254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory ar shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) / Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of performed' death? Yes 2 No 1 Yes Division of Vital filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 2 No Other: INPATIENT 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined To the Hospital within 24 hours a To the Funeral C completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nufse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier completed cause of death (1)em 23a)

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per in g922 12-6-11 vt. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 13 2011 Physician/ WILLIAMS 6:50 PM C. DAVID Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S LANDOVER 7411 BELL HAVEN COURT If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days 1 X M 2 □ F Hours Min. SEPT. II ear 1960 VIRGINIA 51 Director 217 - 78Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 √ Yes 2 □ No MDPRINCE GEORGE'S LANDOVER 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò er than "natural", or items 23a or the Medical Examiner must be Funeral 20785 IISA 7411 BELL HAVEN COURT 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian 11. Marital Status Armed Forces?
1 X Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: AFRICAN AMERICAN 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, the Medic once. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) PROPERTY MANAGER PRIVATE Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ည MARY F. GRANT DAVID WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7467 VILLAGE GREEN TERRACE LANDOVER, MARYLAND 20785 MARY F. WILLIAMS/MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Normalia 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/19/2011 LANDOVER, MARYLAND HARMONY CEMETERY 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ (a tate disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 5 Other (specify) Pregnant at time of death led by the a a Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No pertensit 24a. Was an autopsy performed? Yes 2 2 No page 2 certificate 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 within 2 To the only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month. Day, Year) NOVEMBER 16, 2011 D57039 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BABAK RAZI M.D. 4404 QUEENSBURY ROAD RIVERDALE, MARYLAND 20737 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

NOV 21

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER Day 14 2011 5:03 P M WILLIS В. DOROTHY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY SILVER SPRING HOLY CROSS HOSPITAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Director 577-60-5613 93 1 □ M 2**X** F Yrs AUG. 8 1918 NORTH CAROLINA Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits notified at Director 28a-f MD MONTGOMERY 1 X Yes 2 No SILVER SPRING 10e. Street and Numbe 10f. Zip Code 10q. Citizen of What Country? must be Funeral 23a 12801 OLD COLUMBIA PIKE #215 20904 USA items death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Examiner Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No If Yes, Give Year or Dates. 1 Yes 2 No Specify: Completed 3X Widowed 4 □ Divorced Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) EXAMINER GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 WALTER WIGGINS RUTH CARTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904ALLEN E. DUNSTON/SON 12801 OLD COLUMBIA PIKE #215 SILVER SPRING, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) LINCOLN CEMETERY: 11/23/2011 BRENTWOOD, MARYLAND Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. Naphney 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HEMORRHAGIC SHOCK disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner RETROPERINEAL BLEED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or injury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of) sician Physician/Medical certificate be Box 68760 the phy as ding IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months? Month Year 4 ☐ Pregnant at time of death g ☐ Unknown the 9 Unknown P.O. signed by Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed MULTIORGAN FAILURE peen 24a. Was an Were autopsy findings available prior to completion of cause of has page 2 autopsy performed? death? certificate 1 Yes 2 🗆 No 2 XN Yes 25. Was case referred to medical or Attending Physician: Be 26. Place of Death (Check only one) examiner? 2 X No Other: 1 Yes မှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA within 24 hours after death.

To the Funeral Director: After this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certi-29d. Date signed (Month, Day, Year, Mig). 64100 2011 NOVEMBER 15, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

SMITHA BHIKKAJI M.D.

31. Date filed (Month, Day, Year)

1500 FOREST GLEN ROAD SILVER SPRING, MARYLAND 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene 21,25 per me, g921,11/18/2011 dnb Registrar Certificate of Death Reg. No. 37097 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Wah1 Physician/ Chester Marvin Detober 03:15 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital 07 Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign Funeral Hours NJ Director 156-05-6407 1 X M 2 🗆 F 97 09/20/1914 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director notified 28a-f Boca Raton 1 Yes 2 X No Palm Beach FL 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be 23a 33487 799 E. Jeffrey Street, #304 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) Attorney at Law Legal Juid be file Juil and Mental Hy, Juil them 27 is marked other or other traumatic every Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other traumatic events. ၉ **Mollie Feldstick** Louis Wah1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Blanche Wahl - Wife 799 E. Jeffrey St., #304, Boca Raton, FL 33487 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Arington Cemetery Chizuk Amuno Cong. 1 X Burial 2 Cremation 3 Removal from State 10/30/2011 Baltimore, MD ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sol Levinson & Bros., Inc. 8900 Reisterstown Road, Pikesville, MD 21208 21. Signature of Funeral Service Licensee per DVR Eliza H. Feller 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Sepsis Physician/ 2 days disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Urinam Tract infection and Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICALEX attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be in 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physicis 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Acute Kidney Injury 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Coronary Artery Disease 24a Was an performed? Yes 2 No 2 No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၀ 1 X Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Dav. Year) Romenta RES-000 October, 29, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD Hospital Mehba Sinai 2. Registrar's Signature State

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ KATHERINE WARNKEH 16.3011 NOUEHBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE-WASHINGTON HERICAL CENTER CLEH BUR HIE 1304WAA 444 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 - M 2 1 F 0472671932 Canada Director 216-80-0979 79 Usual Residence of Decedent show ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Severn 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7959 Telegraph Road, Trailer 143 21144 Canada ral", or items? death 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2X No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 ☑ Widowed 4 ☐ Divorced Specify: White Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Kenneth Clark Angeline Pappilon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trainonce. <u>Joanne Kahler</u> <u>69</u> Gardenza Drive, Hanover, PA 17331 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1X Buriat Cremation 3 Removal from State ion 5 Other (Specify) Glen Haven Memorial PK 11/18/11 Glen Burnie, MD 21. Sign 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Council Interval Between Onset and Death Immediate Cause (Final ≁nysician/ disease or condition SEPTIC SHOCK 2 DAYS Medical resulting in death) Examiner 30A45 MOINDRY TOACT INFECTION Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year signed by the a 1 ☐ Yes 2 ☐ Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has page 2 autopsy performe death? Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director After this certific completed filled in by the funeral director, after death.

irector After this certifican by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 No Other: ျ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Definition in the least of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) Discourant Campour, HD P1F52000 HOUEHBER 16,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CUILLERMO DOZE CIPHERECO 301 HOLLILAT DEINE CLEH BURNIE MD JOICI

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 37099 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Lee Month 255 Physician/ Elva Year PM 11 2011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN SQUARE HOSPITal Rosedale LTIMOS 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign **Funeral** Country) Maryland 217-60-2418 1 M 2 F Months Days Hours Min **Director** Usual Residence of Decedent and 2 should be filed within 72 nous ...... f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City-Limits Director Parkville 1 Des 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Jo 15 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.; Black, White, etc. 1 Never Married 2 Married þ 1 Yes Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) of Maryland Social Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev trentiss Dought 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Circle dangerter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Man and sdowne 4 Donation 5 Other (Specify) 22. Name and Address of Facility Service 21. Signature of Funeral Service Licenses 2122 TVC. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ years Dronam disease or condition resulting in death) Medical Examiner 4000 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit a that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Year Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ξ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 N 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☑ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 1 Inpatient 2 FR/Outpatient 3 I DOA ပ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 1 🖳 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 11-16-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

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1401 Madison Park Suite 100 Glenburnie md 21061

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32. Registrar's Sinature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 9:22 AM Physician/ WELLES MICHELLE November 16 2011 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign If Under Social Security Numbeunk **Funeral** Days (Month, Day, Year) 01/26/1963 Country) 1 🗆 M 2 💢 F 47 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State with the Maryland be notified at Director Baltimore 1X Yes 2 □ No MD 10g. Citizen of What Country? 10e. Street and Number ō USA Franklin Street 21201 Funeral items 23a 501 W. the Medical Examiner must · death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Force Completed by 1 Never Married 2 Married Yes 2X No Specify: Black permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Homemaker 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Dorothy Slate Bernard Welles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvia Welles Sister 3223 Esther Place Baltimore MD 21224 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition
1 □ Burial 2 🌣 Cremation 3 □ Removal from State Date cemetery, crematory or other partial Atlantic Crem 11/19/11 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Serv uneral Service Licensee ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between 2ns and Death Immediate Cause (Final sepon Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Enter I Inderlying Physician/Medical Examiner Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Month Dav in the past 12 months? Pregnant at time of death 4 ☐ Pregnant a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed death? 1 Yes 2 No certificate filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: Hospital 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 I this 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After I completed filled in by the funeral 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie November 16, 2011 address of pers Baltinine, Red ST. Paul ST. ate filed (Month, Day, Year) NOV 2 1 2011 32. Registrar's Signature State Barks Registrar

OHMH 17 Rev 7/2009

, 11-07996 Sandra Ballard

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certificate				Z U 1 g. No.	1 3/10			
Physici		Decedent's Name (First, Middle,Last)		Date of Death     Month     October 24		3. Time of Death 1015 hrs					
Medical Exami	iner	Sandra Ballard  4a, Facility Name (if not institution, give street and numb		, 2011 4c. County of Death							
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  9701 Viers Drive #140  4c. County of Death  Rockville  Montgomery									
Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday)			_	(MM/DD/YYYY) 9. Bird	thplace (State or			
Director		577-48-9680 1_M 2\overline{X}F	74	Yrs. Months Day	s Hours Min	6/14/19	937 co	untry[DC			
aoy		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location									
	¥	MD Montgomery	Rockvil	L1e				1 X Yes 2 No			
th the Maryland 23a or 28a-f show	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cour				
ith the 23a or eotific		14009 Parkvale Road  11. Marital Status 12. Was Decedo	ont Euros in H.S. 12.1	20853		pecify Ves or No-	United Sta	can Indian, Black,			
leath w r items	Funeral	1 Never Married 2 Married Armed Force		If Yes, specify Cubar			White, etc.	carringian, black,			
after of	by F	3 Widowed 4 Divorced If Yes, Give Yaar or Dates:	1[	Yes 2 No	specify:		Specify: Whi				
hours natur Exam		15. Decedent's Education (Specify only highest grade of	during	dent's Usual Occupat g most of working life			16b. Kind of Business/I	ndustry			
36 hin 72 e. than '	Completed	Elementary/Secondary (0-12) College (1-4-		omemaker			Own Home				
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Con	17. Father's Name (First, Middle, Last)			18.Mother's Name		aiden Surname)	-			
2121 wld be fi Mental J marked	Be c	Lewis Hamburger  19a. Informant's Name/Relationship (Type, Print )	I 10h Mai	iling Address (Stree	Rose D		per, City or Town, State	Zin Codo)			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygient and England Mental Hygien I manueries to the than I and wasterd other than "natural", or items 23a or 28a-f ahe injury or other traumatic event, the Medical Examiner, must be entitled at occ	To	David Ballard - son	354	46 Russell	Thomas	Lane Day	vidsonville	MD 21035			
re, F s l and f Healt ffitem er trau		20a. Method of Disposition  1	crematory or	position (Name of cer other place)			20c. Location - City or Town, State				
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		4 Donation 5 Other Specify:	Pudean Me	em. Garden		28/11	Olney, MD				
Ball permit Depart Impor		21. Signature of Funeral Service Licensee	M01163 22	2. Name and Address Edward Sag 1091 Ros	s of Facility sel. Funer	al Direc	tion Inc	.0852			
Physician		234 Part I Enter the disease, or complications that caus failure. List only one cause on each line.						Approximate Interval Between Onset and			
الحاله الأسط xaminerيّـ		Immediate Cause (Final disease a. Gunshot Wou						Death			
marine self		or condition resulting in death)  Due to (or as a co	nsequence of):								
	ner	if any, leading to immediate  Due to (or as a co	nsequence of):								
_ b.	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
Division of Vital Records, P.O. Box 68760, to the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Puoreal Director: After this certificate has been signed by the attending physician and completely filled in by the finneral director, page 2 should be detached for use as the burial - transi	SalE	d. UNPENDED AMENDED					·				
760, cate be ex physician the burial	Medical	UNPENDED AMENDED  IF FEMALE: 23c. If yes, out		23d. Date of delivery							
x 687( h certifica tending ph use as the	an/h	23b. Was decedent pregnant in the past 12 months?	2 🗌	Fetal death 3	Ectopic pregna	ancy		Day Year			
Box 687  e death certific  the attending I  ed for use as the	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	at time of death 5	Other (Specify)							
O. Bo at the de d by the stached f		Part II. Other significant conditions contributing to de	eath but not resulting in th	ne underlying cause g	given in Part I.		acco use contribute to	_			
S, P.O nires that t n signed by d be detac	ed by						2 No 3 Prob				
cords law requals been a shoul	Completed					24a. Was ar autops perform	y prior to o	topsy findings available completion of cause of			
tal Recian: The lacentificate h	Com					1 Yes 2		s 2 No			
ictor	Be	25. Was case referred to medical examiner?	atient 2 ER/Outpati		Other Nursin		Residence 6 🗸 Other	" Scene			
iog Phy After thi	1: To	27 Manner of Death 28a Date of I	niury 28b Time		ry at Work?	28d. Describe ho	ow injury occurred				
ion trendic leath. tor: A	ation	1 Natural 5 Pending FOUND: 2 Accident Investigation Oct 24, 20		1 🗆 🗅	Yes 2 V No	Subject shot					
Division of Vital Records, pital or Attending Prystian: The law require ours after death. erral Director. After this certificate has been si filled in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be 28e. Place of	f Injury - At home, farm, s	treet, factory, office b	ouilding, etc.	or Town, Sta	reet and Number or Ru ate)	ral Route Number, City			
Iospita 1 hours 1 hours 1 hours		4 Momicide  29a. Certifier	Nursing Home	curred at the time, da	ate and place, and	-	ve, Rockville, MD	ed.			
Division  To the Hospital or Attent within 24 hours after death To the Fuoeral Director: completely filled in by the	Medical	check only one 2 Medical Examiner: On the basis of e and manner state	xamination and/or investi								
	Me	29b/Signature and title of certifier	\	29c. Licens			29d. Date signed (Moi				
20		( Carrell	)	O.C.I	W. <b>∟</b> .		October 25, 2011				
İ		30. Name and address of person who completed cause of Laron Locke MD. Assistant Medical E		Baltimore Stree	t, Baltimore, I	MD 21223					
	tate	1007 70 0 2011	trar's Signature	wed.							
Regis	trar	NUV U 3 ZUIT Llener	m p. 7	175							

DHMH 17 Rev 1/2001 OCME 2006

OCME

**ORIGINAL** 

11

-07997		Please Type or Print in Bla	ack ind	delible Ink.	Ensure All	Copies Are		0710			
bert Ballard		State of Maryland / - For State legistrar		Reg. No.							
Physicia ledical Examir	ın/	n. Decedent's Name (First, Middle,Last) Albert Ballard				2. Date of Month Octobe	Day Yea er 24, 2011	1015 hrs			
		4a. Facility Name (if not institution, give street and number) 9701 Viers Dr #140			ity, Town, or Location ockville		Montgon	4c. County of Death  Montgomery			
Funeral Director			e (In yrs. la:		Under 1 Year If Un onths Days Hou	re Min	of Birth (MM/DD/YYYY 0/1931	9. Birthplace (State or Foreign Country) China			
nd how any ce.		Usual Residence of Decedent  10a. State 10b. County  MD Montgomery		Town or Location				10d. Inside City Limits 1 Yes 2 No			
ne Maryland or 28a-f show ified at once.	Director	10e. Street and Number 14009 Parkvale Road		101	Zip Code 20853		10g. Citizen of Wh	at Country?   States			
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	— L	11. Marital Status  1 Never Married 2 Married Armed Forces?  1 Yes 2		If Yes, s	cedent of Hispanic C pecify Cuban, Mexic 2  No speci	rigin? ( Specify Yes o an, Puerto Rican, etc		White, etc.			
ours afte natural", xaminer	od by	15. Decedent's Education (Specify only highest grade con	re kind of work done oT use retired)	16b. Kind of Bu	White siness/Industry						
D36 thin 72 h ne. than "p	Completed	Elementary/Secondary (0-12) College (1-4 or 9	j+)	ant		Accou	Accounting				
21215-0036 uld be filed within 72 hours a Mental Hygiene. marked other than "natural e event, the Medical Examin	Be Cor	17. Father's Name (First, Middle, Last) Maurice Ballard									
MD 21.5 d 2 should b Ith and Men n 27 is mari	10	19a. Informant's Name/Relationship (Type, Print) David Ballard - son	e Number, City or Tow Davidsonvi	or Town, State, Zip Code) onville MD 21035							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 77 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from St.  4 Donation 5 Other Specify:	20b. Place of Disposition (Name of cem- crematory or other place) Judean Mem. Garder			Date 10/28/1		City or Town, State			
Baltir permit. I Departme Importa		21. Signature of Funeral Service License	IC IIIe MD 20852 art Approximate Interval								
Physician //viceical		23a Part I. Enter the disease, or complications that caused failure. List only one cause on each line.  Immediate Cause (Final disease a. Intraoral Gunsh			ode of dying, such a	s cardiac or respirato	ry arrest, shock, or he	Between Onset and Death			
≟xaminer		or condition resulting in death)  Due to (or as a consequence of):									
	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated									
ecuted and transit	I Exar	events resulting in death) Last  Due to (or as a cons									
an an	edical	UNPENDED AMENDED	me of pregu	nancy			23d. Date of	f delivery			
Box 68760, e death certificate be the attending physic of for use as the bur	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   23d. Date of del Month   2   Fetal death   3   Ectopic pregnancy   Month   4   Pregnant at time of death   5   Other (Specify)   1   Yes   2   No 9   Unknown   9   Unknown   9   Unknown   1   Unk									
res that the de signed by the	by	Part II. Other significant conditions contributing to deal	h but not re	esulting in the unde	rlying cause given in			ibute to the cause of death?  Probably 4 Unknown			
cords law requires been bas been 2 should	Completed					_	autopsy	Were autopsy findings available prior to completion of cause of death?			
ital Reciens: The scertificate	Be	25. Was case referred to medical examiner? Hospital: 1 Inpution	ent 2	ER/Outpatient 3	I Other	th (Check only one)  Nursing Home	5 Residence 6	✓ Other: Scene			
	tion: To	27. Manner of Death  1 Natural 5 Pending Oct 24, 2011	ury	28b. Time of Injur 0954 hrs		Subject	red				
Division ra for Attendi rs after death.	Certification:	2 Accident Investigation 3  Suicide 6 Could not be determined (Specify) Nt			actory, office building		ation (Street and Numb own, State) ers Dr #140, Rockvi	per or Rural Route Number, City			
Divisi To the Hospital or Att within 24 hours after d To the Funcral Direct scompletely filled in by	Medical Co	29a. Certifier 1 Certifying Physician: To the best of m (Check only one) Medical Examiner: On the basis of example and manner stated	amination a	ge, death occurred and/or investigation,	at the time, date and in my opinion, death	place, and due to the	e cause(s) and manne , date and place, and	r as stated. due to the cause(s)			
70	Me	29b. Signature and title of certifier			29c. License num O.C.M.E.	per	29d. Date sign October 2	ned (Month, Day, Year) 5, 2011			
		30 Name and address of person who compreted cause of Laron Locke MD. Assistant Medical Ex	death (Item	n 23a) 900 \W Raltin	nore Street Ra	Itimore MD 212	23				
<u>s</u>	tate	31. Date filed (Month, Day, Year). 32. Registr									
Regis	trar	NUV U3 ZUIT Kensus	1 19.	19000							

11-08473 Betty Bradford Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Ce	leg. No.							
Physici edical Exam		Betty B. Br	radford			2. Date of Dea Month Novembe	Day Year	3. Time of Death 1550 hrs		
		Facility Name (if not institution, give street and number)     Glade Valley Center		4b. City, Town, o Walkersvill		eath	4c. County of Frederick	Death		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 193–10–3655 1 M 2 F 95		Months Day				9. Birthplace (State or Foreign PA		
and f show any nce	or	Maryland   Frederick   F	y, Town or Loca Frederi	ation Ck				10d. Inside City Limits 1 X Yes 2 No		
ithe Maryland a or 28a-f show ptified at once.	Director	10e. Street and Number 810 Stratford Way C		10f. Zip Code 21701		1	0g. Citizen of What USA	Country?		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 71 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Manital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced If Yes, Give Year or Dates:  12. Was Decedent Ever in U Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)	1	/as Decedent of His Yes, specify Cubar Yes 2 No	n, Mexican, Pue	erto Rican, etc.)	White, e	Thite		
036 ithin 72 hou ne. r than "nati	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during r	ent's Usual Occupa most of working life ales Cler	DO NOT use		16b. Kind of Business/Industry Retail			
21215-0036 und be filed within 7 Mental Hygiene. marked other than	Be	Charles Betts	Maiden Surname) ningham							
MD 2. nd 2 should alth and M m 27 is ma	오	19a. Informant's Name/Relationship (Type, Print) Betsey Gibson/Daughter 20a. Method of Disposition	810 9	ng Address (Stree Stratford	21701					
Baltimore, permit. Pages 1 ar Department of Hee Important: If itel		1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:	crematory or o auffer	Cremator	ту 11	Date 1/12/2011	20c. Location - City or Town, State  Old Frederick, MD			
	21 Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Ho									
Physician /Medical .xaminer		23a. Tail . Enter the disease or complications that caused the death. failure. List only on souse on each line. Hypertensis Immediate Cause (Final disease or condition resulting in death)	ve Athe	erosclero	tic Car	c or respiratory arrediovascu	est, shock, or heart lar Disea	Se Approximate Interval Between Onset and Death		
	ē	or condition resulting in death)  Due to (or as a consequence of b.  Sequentially list conditions, fit any, leading to immediate  Due to (or as a consequence of b.)								
id sit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of								
760, ficate be executed g physician and the burial - transit	/Medical E	M UNPENDED AMENDED 23a,pt.	11,27,2	28a-f,per	me,g92	2 12-15-	II sm			
Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 ✓ No 9 Unknown  23c. If yes, outcome of pregr 1 Live birth 4 Pregnant at time of deceded.	ivery Day Year							
P.O.	ā	Part II. Other significant conditions contributing to death but not revertebral Fracture, Osteoporos	e to the cause of death?  Probably 4 Unknown							
cords law requ has been	Completed	24a. Was an autopsy prior to performed? death?								
Vital Recysician: The his certificate director, page	Be	25. Was case referred to medical examiner?			of Death (Chec	k only one)		Yes 2 No		
Physic rr this or	P	1 Yes 2 No No Inpatient 2	ER/Outpatient				Residence 6 🗸 C	ther: Scene		
C # _ ^ #	ation:	2 Accident Pending Investigation Investigation	28b. Time of I fd:7:0 Approxim	0 ate 1□ Y	y at Work? 'es 2 X No	subject				
<u>&gt; ₽ € ¥ ≅</u>	Certification:	3 Suicide 6 Could not be determined (Specify) nursing 29a. Certifier	Rural Route Number, City alley Center							
Div To the Hospital or within 24 hours afte To the Funeral Di completely filled in	Medical	(Check only one) 2 Medical Examiner: On the basis of my knowledge and manner stated.		tion, in my opinion,	death occurred		and place, and due t	o the cause(s)		
	29b. Signature and title of certifier  29c. License number  O.C.M.E.  November 12, 20									
٦		30. Name and address of person who completed cause of death (Item. Donna M. Vincenti, MD Assistant Medical Exam	niner 900	W. Baltimore	Street, Balti	imore, MD 212	223			
Sta Regist		31. Date filed (Month Day, Year) 2011 32. Registrar's Signatur	ie. Ac	aked						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ NOVEMBER 2011 06:30 AM ROBERTA J. COLEMAN Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner UNION HOSPITAL OF CECIL COUNTY ELKTON CECIL . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, AUG • 9 • 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Min. Days WEST VIRGINIA 1 □ M 2**X** F Months Hours 235-50-2567 .1933 Director 78 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and I filew 27.5 is marked other than "natural", or items 23a or 28a-f sho and I filew 27.5 is marked other than "natural", or items 23a or 28a-f sho up or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2X No MARYLAND ELKTON CECII 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral UNITED STATES 590 MIDDLE ROAD 21921 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2XXNo Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: Specify: WHITE If Yes, Give Year or Dates Completed 3 ₩Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ CINDERELLA LONG JOHN CHAPPEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other troone. 590 MIDDLE ROAD, ELKTON, MARYLAND DENISE BRADFORD / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State NOVEMBER 8. 1 Burial 2XXCremation 3 Removal 4 ☐ Donation 5 ☐ Other (Specify) 2011 MAYERDALE CREMATORY NEWARK, DELAWARE 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. SOUTH MAIN STREET, NORTH EAST, MARYLAND 21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failule. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to jor as a consequence of cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1  $\square$  Live Birth 2  $\square$  Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No signed by the atte Month Year Other (specify) Pregnant at time of death g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Dementia 2 No 3 Probably 4 Unknown Completed phone 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe CAD 1 Yes 2 No 1 ☐ Yes 2 🔀 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: Other: 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA ျှ 4 Nursing Home 5 Residence 6 Other (Specify) this Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work?
1 Yes injury X Natural 5 Pending 2 🗌 No Investigation Accident within 24 hours after death

To the Funeral Director: A

completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4  $\square$  Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one title of certifier 29b. Signature a 29d. Date signed (Month, Day, Year) D0062190 MD 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 533 AUGUSTINEHERMAN HUY, SUITEA, CHESAPEAKECITY, MD 21915

Registrar DHMH 17 Rev 7/2009

State

SHAHNAWAZ

32. Registrar Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-08366 State of Maryland / Department of Health and Mental Hygiene John Robert Cook 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) Physician/ Cook, Jr. **Medical Examiner** John Robert **Funeral** Director Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygienc.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.

Physician VMedical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		4a. Facility Name (if not institution 402 South Horners La	4b. City, Town, or Location of Death  Rockville						4c. County of Death  Montgomery					
									rth(MM/DD/YYYY) 9. Birthplace (State or					
neral ector		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  218-02-0627 1 N 2 F 38 Yrs.		Months	Days	Hours	Min.		4/19	i	Foreign	Washington D.C.		
	H	Usual Residence of Decedent	тдант 2										L	2.0.
A III	1	10a. State 10b. County		10c. City, To	own or Loca	ition								10d. Inside City Limits
show .	'n	MD Monts	gomery	0	lney									1 Yes 2 No
28a-f   at or	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country										ry?		
3a or														
t be n	Funeral	11. Marital Status  1 X Never Married 2 Mar	13. W	as Decedent Yes, specify	of Hispa Cuban, N	anic Origii Mexican, I	n? ( Spe Puerto R	cify Yes or Nicify Yes or Nicify Yes	No-	14. Race - American Indian, Black, White, etc.				
r mus			1 Yes orced If Yes, Give Ye	2 X No ar	₁┌	1 Yes 2 No specify: Specify: Whi							Whit	e
tura,	d b	or Dates: or Dates: 150 August 15											dustry	
n "na	ete	Elementary/Secondary (0-12) College (1-4 or 5+)									-			
er tha	Completed	12	0		Lan	dscape		1 8 a 41 - a -d -	None /	Ciant Affectato			culture	
t the		17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  John Robert Cook, Sr.  Najla Allein Harb												
Menta mark even	o Be	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
27 is	-	John R. Cook, Sr. / Father 8605 Augusta Farm Lane, Laytonsville, MD 20882												
item		20a. Method of Disposition	2 🗆 🗆			sition (Name ther place)	of ceme	etery,		Date	20c.	Location -	City or T	own, State
r othe		1 Burial 2 Cremation 4 Donation 5 Other St	_	TOTH State		Churc	n Ce	m.	11/1	1/11	Ro	und H	lil1,	Virginia
Department of Health and Mental Hygienc. Important: If item 27 is marked other than "natural", or items 13a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee		22.	Name and A Murie	dress o	Facility Bar	ber	Funer	al H	Iome		
	- 1	10/6 / NO	assentiantians that	covered the death. D	lo not enter	P O	Bo	x 50	38	Laytor	nsvi	11e	MD	20882 Approximate Interval
ician dical		failure. List only one cause on each line.  Between Onset and Death												
niner		Immediate Cause (Final disease a. Alcohol and Oxycodone Intoxication  or condition resulting in death)  Due to (or as a consequence of):												
		Sequentially list conditions, b												
	miner	if any, leading to immediate causa. Enter Underlying Causa	Due to (or as	a consequence of):										
nsit	.0	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.												
ian and ial - tra	Physician/Medical Exa	▼ UNPENDED												
physic the bur	/Mec	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes	outcome of pregna				7			23	3d. Date of		
ending use as	cian	23b. Was decedent pregnant in the past 12 months?  4 Pregnant at time of death 5 Other (Specify)  Month Day										ay Year		
the atte	nysi	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown  Part II. Other stantificant conditions. contribution to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?												
ed by detach	by P	A TWO OF THE OF PROPERTY AND REPORT OF THE PROPERTY AND REPORT OF THE PROPERTY AND REPORT OF THE PROPERTY OF T												
en sign	ted	Chronic Alcohol Abuse 2 No 3 Proba										opsy findings available		
has be 2 shor	Completed								_	per	topsy rform <u>ed</u> ?	d	eath?	ompletion of cause of
ficate r, page	Cor	05.144				26	Place	f Death (	Check or		s 21	No 1	<b>✓</b> Yes	2 No
is certi	Be	25. Was case referred to medica examiner?	Hospital: 1	Inpatient 2 E	R/Outpatie		10	46		Home 5	Resid	dence 6	Other:	Scene
fter th	5	1 Yes 2 No 27. Manner of Death	28a. Dat	e of Injury 2 th, Day,Year)	28b. Time o	f Injury 28	c. Injury	at Work?	? [2	28d. Describ	e how in	njury occurre	ed	
eath. <b>or:</b> A the fu	itio	1 Natural 5 Pend 2 Accident Inve	ding .		Ed:192	28 hrs	1 Ye	s 2X	No L	ınknow	'n			
ufter d Direct in by	Certification:	3 Suicide 6 X Cou	ld not be 28e. Pla	ice of Injury - At hom			office bui	ilding, etc	. [2					al Route Number, City Horners Ln
neral filled	Cen	4 Homicide		outside-f						ockvi				
within 24 hours after death. <b>To the Funeral Director:</b> After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	(Check only   Certifying P	hysician: To the be miner:On the basis and manner	est of my knowledge s of examination and stated	e, death occ d/or investig	urred at the t ation, in my o	me, date pinion, o	e and placedeath occ	ce, and c curred at	the time, da	iuse(s) a ite and p	lace, and d	ue to the	cause(s)
¥ 1 8	Æ	29b. Signature and title of certific		·c/			License							th, Day, Year)
		Celus	ul	X	7		O.C.M	.E.			No	vember	ಶ, 201 —–	1
		30. Name and address of person Zabiullah Ali, M.D.	who completed ca Assistant Med			Baltimore	Stree	t. Baltir	nore.	MD 2122	3			
٥	tate	at B t States at B t Mark	32. F	Registrar's Signature										
Regis		NOV 1 6	0044   8	Energy &	9. 10	ale								

37105

3. Time of Death

1940 hrs

Reg. No

Month Day November 7, 2011

2. Date of Death

Registrar

NOV 2 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ JOSEPH EDWARD DePINA OVEM BER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHARLES MEDICAL PLA ENTE - WISTA 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Days 1 ⊈M 2 □ F Months BERMUDA 048-28-3991 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State death with the Maryland Director LA PLATA 1 Yes 2 No MD. CHARLES 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ò items 23a or ner must be n Funeral U.S.A. 20646 2001 BARLEY DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 \sum No ARMY
If Yes, Give 1 9 5 4 - 6 2
Year or Dated. Black, White, etc. "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry
MIZZY CONSTRUCTION 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) NOWICH.CT. CONSTRUCTION FOREMAN 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ GRACE WOODLEY is marked JOSEPH GODWIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trauonce. LA PLATA, MD. 20646 2001 BARLEY DR. KIM LOTT-DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 11-15-11 METROPOLITAN CREMATORY ALEX., VA. 4 ☐ Donation 5 ☐ Other (Specify) M00479 Ome and Address of Facility
AYMOND FUNERAL SERVICE, P.A.
,A PLATA, MARYLAND 20646 21. Signature of Juneral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ MON disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Few MO sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be DEPIN Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC (BST RUCHVE PUMONAL) 23e. Did tobacco use contribute to the cause of death? Completed by OBSTRUCTIVE 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Matural 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred injury 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the f Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of gertifier 29c. License number NOVEMBER 122011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL 32. Registrar' Signature

State Registrar

CL

10SEP

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Records,

**Division of Vital** 

CHARLES HAVILAND MOCRE 12500 WILLOWBROOK RD, CUMBERLAND, MD

D72287

Nev 15,2011

21502

IMOORE, M.D.

NOV 2 1 2011

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 29 2011 1:45 A M Brenda R. Greenfeld Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Manor Care- Potomac Potomac If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Month, Day, Year 1936 Months Days Hours 578-48-4687 Nov. **Director** 1 M 2 X 74 Washington, DC Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location Director ral", or items 23a or 28a-f s Examiner must be notified 1 X Yes 2 No MD Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20854 U.S.A. 11012 Powder Horn Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: "natural", Completed White 3 XWidowed 4 Divorced Year or Dates er than "natur, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N any injury or other reaumatic event, the N any injury or other traumatic event, the N any injury or other traumatic Retail Clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mildred Vera Understein Joseph Gins 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12104 Damson Drive, Gaithersburg, Maryland 20878 <u>Steven H. Greenfeld/Son</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Mt. Lebanon Cemetery 10/31/2011 Adelphi, Maryland 22. Name and Address of Danzansky-Goldberg Memorial Chapels. 21. Signature of Funeral Service Licensee mo1597 Mcgreenta 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dialated Cardiomyopathy Physician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Rheumatic Fever Sequentially list conditions, Examiner if any leading to immedicause. Enter Underlying and -----Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 38 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Day Month Year Pregnant at time of death ate has been signed by the a page 2 should be detached to g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 2X No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 🖳 No မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🛣 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work?
1 ☐ Yes 2 ☐ No 1 XNatural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) and title of certifier 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number D50534 October 29, 2011 lD romas Wastevan Mi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Masterson, MD 6858 Old Dominion Drive #104, McLean, Virginia 22101

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Tohn Thomas Gray 2011 ам 9:55 Medical November 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5910 Carlton Lane Bethesda Montgomery Social Security Number 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min Hours 577-34-7279 **Director** 1 X M 2 □ F 86 Oct. 3, 1925 VA Usual Residence of Deced 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Montgomery Bethesda 10e. Street and Number ò 10f. Zip Code 10a. Citizen of What Country? Funeral items 23a 5910 Carlton Lane 20816 IISA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, the Medical Examiner Black, White, etc ò 1 Never Married 2X Married þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify: 'natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene.
is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Accountant IBM Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ traumatic Randolph Thomas Gray Beulah Taylor 19a. Informant's Name/Relationship (Type, Print) Department of Health are Important: If item 27 is a any injury or other traum once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gertrude T. Gray/Wife 5910 Carlton Lane, Bethesda, MD 20816 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c, Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Nov. 4, 4 ☐ Donation 5 ☐ Other (Specify) of Heaven Cemetery 2011 |Silver Spring, MD 21. Signature of Funeral Service License Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 3 yrs. 23a. Part : Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Phylician/ Cancer of the Prostate disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) burialor Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Dav Year Pregnant at time of death be detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Congestive Heart Failure 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24a. Was an 24b. Were autopsy findings available has page 2 prior to completion of cause of death? autopsy perform this certificate 2X No 1 Yes 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: 1 Yes Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 🗷 Natural 5 Pending injury after death Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier pletely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 D12121 November 2, 2011

State Registrar George F. Sengstack,

30. Name and address operson who completed cause of death (Item 23a) (Type, Print)

## Amend 20b, per fh. g921 11-21-11 sm. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20

			For State Registrar		Cer	tificate of	Death		teg. No.						
	Physici	an	1. Decedent's Name (First, Middle, La. 01iver	•	.land		2. Date of Dear Month	Death Say Year 3. Time 7							
-	/Medic Examin		4a. Facility Name (If not institution, giv 3648 Dory Bro	e street and number)		4b. City, Town, o	Nov. 6, 2011   5:1  b. City, Town, or Location of Death hesapeake Beach  Volume 1								
	Funeral Director		214-30-0403	ex 7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Mar.13	Year) , 1932	9. Birthpl Coun	lace (State or a	Foreign			
	land Dw		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation				10	0d. Inside City	Limits			
	8a-f she	Director	MD Calver	t Cl	esap	eake Be	each				1 □Yes 2	₽ <b>™</b> No			
	ath with the 23a or 2		10e. Street and Number 3648 Dory Br	ooks Road		10f. Zip Code 2073			USA	0g. Citizen of What Country? USA					
9036	2 should be filed within 72 hours after death with the Maryland and Mental Hygene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Extendent must be ruffiled at	d by Funeral	11. Marital Status  1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 1 Mo If Yes, Give Year or Dates:	i	Was Decedent of H f Yes, specify Cuba 1 □ Yes 2 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Ye's or No- o Rican, etc.)	Blad	ce - America ck, White, e y: B1a	etc.				
215-0	iin 72 ho ii in "natu Medicel	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occup kind of work done DO NOT use retire nt Fini	during most of wor		16b. Kind of Br		•				
1212	led within Hygiene. her than " nt, In Mo		Elementary/Secondary (0-12)  UK   17. Father's Name (First, Middle, Last,		Ceme	nt Fini		ne (First, Middle, i	Constr		on				
/Janc	uld be fi Vental H Irked ot Itic ever	To Be	James Owe	<i>ic)</i>											
, Mar)	s t and soft Health item 27		19a. Informant's Name/Relationship (Mary C. Hollan	" /	,							ach, MD 20732			
Baltimore, Maryland 21215-0036			20a. Method of Disposition  1 Surial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification)	Removal from State $\overset{20b. \ Pla}{cer}$	netery, cren ch		em. 11/	11/11		n, M	D				
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licer	Sewell	1	2. Name and Addre 451 Dar	es Beac	well Fu h Rd. I	neral Prince	Hom Fre	e, P.A d.,MD2	2067			
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. The oscillar of the consequence of the consequence of the consequence of the consequence of the consequence of the conditions.  Seguentially list conditions,												
68760,	rtificate be executed ng physician and as the burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	·										
O. Box	eath ce attendi for use	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown	eath 3	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	÷у			ate of deliver		ear			
rds, P.	w requires that the dibeen signed by the should be detached		Part II. Other significant conditions of	contributing to death but not result		nderlying cause giv	ren in Part I.		bacco use cont es 2 □ No	tribute to th	***				
of Vital Records,	The ate h	Completed by	Hyportens	ive Hear		lisease		24a. Was a autop: perfor 1 □ Yes	sy med? 2 ⊠No	24b. Were autopsy findings available prior to completion of cause of death?  □ 1 Yes 2 No					
≅	Physician: r this certific ral director, I	) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 📆 No	Hospital: 1 ☐ Inpatient 2 ☐ E	D/Outpation	oth		th <i>(Check only or</i> lome 5 <b>⊠</b> Resid		205 (04					
on of	Attending Phys r death. ector: After this by the funeral dir	tion: To	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	8b. Time of Injury	f 28c. Inju Wor		28d. Describe h			<u>y)</u>				
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		e, farm, str	eet, factory, office	१८०४ व्यक्त - २०२२ व	28f. Location (S City or Tow	(Street and Number or Rural Route Number, wn, State)						
	e Hospita 124 hours e Funeral letely fille	Medical C		nysician: To the best of my know niner: On the basis of examination and manner stated.											
	V Vithir Comp	Me	29b. Signature and title of certifier	· c - Sun	ave	29c. Licens	se number 5065	-3	29d. Date signe	d (Month,	Day, Year)				
	( 8h		30. Name and address of person who 5651 - Dec			Print) GY	5065 MN C U. T	. SWA	ANA M'D	> 7	2075	i			
4	Sta Registr		31. Date filed (Month, Day, Year) NOV 2 1 2011	32. Registrar's Signatu	re V	,	•		.,.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Day 3 4a. Facility Name (if not institution, give street and number) 8.11M Medical **Examiner** 4b. City, Town, or Location of Death 4c. County of Death If Under . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1×2 M 2 🗆 F Months Min. 1 25 7 1 9 4 8 217-50-0107 63 Yrs MD<sup>try)</sup> **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director Delta PA York 1X Yes 2 No 2 should be filed within 72 nows...
Ith and Mental Hygiene.
127 is marked other than "natural", or items 23a or 28:
......aric event, the Medical Examiner must be not 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral P.O. Box 277/410 Main Street 17314 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 10D 18. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give 1 etnam
Year or Dansi etnam Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryĺand 21215-0036 1 Yes 2X No Specify: White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Forklift Operator 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carrie Ruth Hackler Robert Floyd Hale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
PO Box 277/410 Main Street, Delta, PA 17314 19a. Informant's Name/Relationship (Type, Print) Dianna Hale/Wife 27 Department of Healtl Important: If item 2 any injury or other I injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify Evans Eagle Cre. 11/15/11 Leola, PA 21. Signature of Aunaral Service Lic Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph. sician COronar disease or condition me year ac Medical resulting in death) Due to (or as a cons a uence of): **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ for in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death g Unknown Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Completed Unknown Record 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate 2 No Yes 1 Yes Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral of 27. Manner of Death 1 Natural
2 Accident
3 Suicide 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After of completed filled in by the funeral 28d. Describe how injury occurred 5 Pending work? Division 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) Seiax of person who completed use death (Item 23a) (Type, Print) ulie Masa aughner 31. Date filed (Month, Day, Year, 32. Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23a Per PHY G923 1/04/2011 JH. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10/30/2011 NATHANIEL G. HARRIS, IV Medical :00 a Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Village Rehab Montgomery Village Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Country) WV 9. Birthplace (State or Foreign Days 1 🗶 M 2 🗆 F 07/13/1941 Yrs. Director <u>232-60-4913</u> show or 28a-f shown notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Gaithersburg 1 X Yes 2 ☐ No MD Montgomery 10e. Street and Number ms 23a or must be r ö 10f. Zip Code 10g. Citizen of What Country? Funeral Court, #315C 20877 8 Maplewood U.S.A items be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. er than "natural", or ite Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Master Barber Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Nathaniel G. Harris, III Eleanor Edwards permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2624 N.Everly Drive, Frederick, MD 21701 Cecilia Harris /wife altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial Cremation 3 Removal from State 11/2/2011 4 Donaglog 5 Other (Specify) Ardent Crematory Hanover, MD 22. Name and Address of Facility Snowden Funeral Home F neral Service Lice 246 N. Washington St. Rockville, MD 20850 tions that caused the death cause on each line. 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one of not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Metastatic Lung Carcinoma Immediate Cause (Final Physician. Etastatis edencercinema g colon Due to (or as a curs juence of): disease or condition Motactatic Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events Due to (or as a consequence of): burial-transit Exami voin thrembosis and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be Hypertension Box 68760 as the l IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ for in the past 12 months? Month Day Pregnant at time of death Unknown Year signed by the a d be detached f Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, pro monia 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death? performed? Yes 2 No certificate 1 Yes 2 K No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🛣 No Hospital Other: ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier ant us 29c. License number 29d. Date signed (Month, Day, Year) D41162 November 1, 2011

State

Registrar

Vinu Ganti, MD, 19529 Doctor's Drive, Germantown, MD 20874

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NOV 03 2011

State of Maryland / Department of Health and Mental Hygiene 2 [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 135 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bultimore University of Marxand Medical If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 231-78-8551 1 XM 2 - F Months Hours Min 55 Director Jűlÿ11,1956 Vîrgînia Usual Residence of Decedent or 28a-f shov 10b. County 10a, State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland Anne Arundel Glen Burnie 1 Yes 2 No 10f. Zip Code 10q. Citizen of What Country? 23a Funeral 6502 Eiderdown Court 21060 United States or items death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after If Yes, Give 1985-1993 Year or Dates 985-1993 "natural". 1 ☐ Yes 2 XNo Specify. 3 Divorced Specify: Native - American Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) Officer Corrections Dept. is marked other Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) and Mental ဂ္ James Sherman Jefferson Nantee Adkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Pauline L. Jefferson -wife 6502 Eiderdown Court Glen Burnie, Maryland 21060 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Samaria Baptist Church Cerr. 11/12/2011 Charles City County, VA Signature of Funeral Service Licensee Bonald Av. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician) disease or condition multide musermo Medical resulting in death) Due to (or as a consequent e of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) burial-transi Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ To the Hospital or Attending Physician: The law requires to within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 1 ☐ Yes 2 K No 1 Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury work Accident Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 717287 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Glosm, 22 Greene Street. Bultimore, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Month Physician/ 10/30/2011 4:27 p<sup>M</sup> Edith В. Krohn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brighton Gardens North Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Director 186-14-0364 1 □ M 2**X**□ F 98 June 23,1913 Pennsylvania Usual Residence of Deceden 28a-f show nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland atment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ortant: If item 27 is marked other than "natural", or items be notified at injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Maryland North Bethesda Montgomery 10e. Street and Number 10g. Citizen of What Country? Funeral 5550 Tuckerman Lane 20852 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify. 3 X Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Psychology 5+ Clinical Psychologist Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ပ Morris Beckman Pauline Goldman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1330 Weber Street, Alameda, California, 94501 Dr. Susan Kuner/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If iter any injury or oth 20c. Location - City or Town, State 1 x Burial 2 ☐ Cremation 3x Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beth Israel Cemetery: 11/02/2011 Lebanon Co., PA 17064 21. Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. MO 152 11800 New Hampshire Ave., Silver Spring, MD20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. mode of dving, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final Promician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) 130 attending physician I for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery e past 12 months? Yes 2 No in the past 12 Month Dav Year signed by the a 1 ☐ Yes 2 ☐ Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page Yes 2 No 2 🗌 No 1 🗌 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 
Yes Other: 2. No Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of 2011. ho completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Ajay Reddy,

31. Date filed (Moi

M.D.,

3200 Tower Oaks Blvd., Suite 110, Rockville, Maryland 20852

For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Milbourne Bernie Lee November 2011 21:56P. M Medical 4b. City, Town, or Location of Death Annapolis 4a. Facility Name (if not institution, give street and number Anne Arundel Medical Cen 4c. County of Death Examiner Center Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 55 Hours Min 219-68-5559 1 ₹ M 2 □ F Director Sept.4,1956 Maryland Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Oueen Anne's Oueens town 1 Xyes 2 □ No 10e Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? 23a 6129 Main Street 21658 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. o à 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: "natural", Completed 3 Widowed 4 X Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sheet Metal Worker Stromberg Sheet Metal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Thomas Milbourne Ruth Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Diane Frances Milbourne-daughter 6129 Main Street Queenstown, Maryland 21658 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Ivy Hill Cemetery 11/14/2011 Laurel, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License ²Đơnald ⁴V∵s Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ encephalo disease or condition resulting in death) Medical Examiner Segmentially list our citions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury and that initiated events resulting in death) Last physician a s the burial-Physician/Medical requires that the death certificate be P.O. Box 68760 as 1 use a 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Day Pregnant at time of death ed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? certificate 1 Tes Yes Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Yes 2 100 မျ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 Natural 2 Accident (Month, Day, Year) injury 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical 29a. Certifier 1-Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year (Item 23a) (Type, Print) 30 Name and address of erson who completed cause of death 31. Date filed (Month, Day, Year, 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Kathleen Ellen Muir **Physician** 2:50 A 14, 2011 November /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington Hagerstown Golden Living Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Year) **Funeral** 1 □ M 2 🖔 F Months Yrs. 92 April 17,1919 West Virginia 218-30-7598 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "naturel", or frems 23s or 28s-1 show other traumatic event, it a Medical Example in must be notified at 1 Yes 2 □ No Directo Hagerstown Maryland Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A.21740 133 King Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ai Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Hospital Labor 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be fill and Mental H Letha Belle Rankin Arthur B. Shriver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) is 1 end 2 soft Health are item 27 io 720 Oak Hill Ave. Hagerstown, Maryland 21740 (Daughter) Judy Morningstar 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Pages 1
Department of H
Important: if itel
any njury or oth cemetery, crematory or other place) November 1 

Burial 2 □ Cremation 3 □ Removal from State Hagerstown, Maryland 18, 2011 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 22. Name and Address of Facility 21. Signature of Fun ral Service Licensee J.L. Davis Funeral Home mis 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alkeroscleratu Cardio-vosculou des esse 24600 Physician /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Il-transit The lew requires that the death certificate be executed Due to (or as a consequence of): attending physicien a Physician/Medical d IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4 Pregnant at time of death ed by the a 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cete hes been si , page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No After this certificete funeral director, pag 1 Yes 20 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Certification; 1/2 Natural 2 Accident 5 Pending 1 Tes 2 No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide

Box 68760, o. ۵ Records, Division of Vital Physician: Attending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 6 the Hospitel

Baltimore, Maryland 21215-0036

eu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street 1+agestam 1910 WPI 368 reell AR 31. Date filed 32. Registrar's Sgnature

TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

128365

29d. Date signed (Month, Day, Year)

11-14-11

DHMH 17 Rev 1/200

State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medica

and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 06:10 P M Milburn October 26ay 2011ear Car1 L. Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Montgomery Arbor Place Rockville 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 272-18-7278 **Director** 1 ▼ M 2 □ F July 13, 1923 Ohio 88 Usual Residence of Decede aţ 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits rector r 28a-f sl notified Falls Church VA Fairfax 1 XYes 2 No Ö 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funera 6409 Eppard Street 22044 USA within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 If Yes, Give
Year or Dates. Black, White, etc. orces? 2 □ No 1844 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify White Completed ntal Hygiene.

ed other than "natur:
event, the Medical E Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Brown and Bigelow Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If Item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Robert Milburn Doris Lutman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6409 Eppard Street, Falls Church, Virginia 22044 David Milburn/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 🔀 Cremation 3 🔀 Removal from State National Crematory 10/31/2011 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Accilyington Funeral Home 22203 Magneenhat mo1597 3901 North Fairfax Drive, Arlington, Virginia 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 2 Pnset and Peath Physician/ Metastatic Melanoma disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events the attending physician, and resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year should be detact signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Type II Diabetes Mellitus 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy performed Yes 2 X this certificate 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specific Ving 1 Yes 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer X Natural 5 Pending work' 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 D0035045 October 27, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip Henjum, MD. 18109 Prince Philip Drive, Suite 200, Olney, Maryland 20832 31. Date filed (Month, Day, Year) State NOV 03 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEMBER 2ď1 1 04:12PMM GREEVER WITTEN MITCHEM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CECIL 125 CARTER ROAD ELKTON Social Security Numbe 6. Sex 1 XM 2 D F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Davs Hours JUNE 2, Yel 931 80 VIRGINIA **Director** 231-36-8118 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo MARYLAND CECIL ELKTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 21921 125 CARTER ROAD death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 be filed within 72 hours after WHITE 1 ☐ Yes 2 🛣 No Specify. 3 Widowed 4 Divorced Specify: Completed Year or Dates nd Mental Hygiene. marked other than "natur matic event, the Medical | Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) JANITORIAL SERVICE OWNER SELF EMPLOYED Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) BARBARA NIPPER JOHN TATE MITCHEM other traumatic t. Page 1 and 2 should by treent of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 CARTER ROAD, ELKTON, MARYLAND 21921BARBARA HICKMAN / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State NOVEMBER 9. 1 X Burial 2 Cremation 3 Removal from State NORTH to EAST to UN TIPED (c) 4 Donation 5 Other(Specify) METHODIST CEMETERY 2011 NORTH EAST, MARYLAND 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. SOUTH MAIN STREET, NORTH EAST, MARYLAND21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Pulmonary Disease nset and Death Immediate Cause (Final Physiciani reas disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examil and -tran Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Dav Year Pregnant at time of death the 9 Unknown q Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Peripheral Vascular Disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has autopsy page 2 To the Hospital or Attending Physician: The within 24 hours after death. 1 Yes 2 No 25. Was case referred to medical rector, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital 1 🗌 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director, After completed filled in by the funer 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and itle of certifier 29d. Date signed (Month, Day, Year) Jackder 5 MD 11. 7. 2011. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ElkTm MD 21921. SS SACHDEN MD, 186 A, E High

DHMH 17 Rev 7/2009

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				State of Maryland / De			Mental Hygi	iene					
			1 - State Registrar Certificate of Death Reg. No. 2										
	Physicia	an/	Decedent's Name (First, Middle, Last)				Date of Death     Month	Death Jay Year 3. Time of Death					
-	Medi	cal		y, Sr.				n 2, 2011	8:05 P. <sup>M</sup>				
	Examir	ner	4a. Facility Name (if not institution, give street	et and number)		Location of Death		4c. County of D					
	Funeral		4601 Highboro Ct.  5. Social Security Number 6. Sex	7. Age (In yrs. last birthda)	Mt. Air		8. Date of Birth	Freder	Cick Birthplace (State or Foreign				
	Director		220-28-5236 1 X N	12□F 78 <sub>Yrs.</sub>	Months Days	Hours Min.	(Month, Day,	Year)	Country)				
	7 MO 4	1.	Usual Residence of Decedent				July 16,	,1933 V	irginia				
	ryland -f sh ied at	턍	10a. State	10c. City, Town or Mount	Location Airy				10d. Inside City Limits				
	r 28a notif	Director	10e. Street and Number	Tiodit.	10f. Zip Code				1 ☐ Yes 2 No				
	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	ra	4601 Highboro Cour	Ė	21771			0g. Citizen of What United S	Country? States				
	eath v	Funeral			3. Was Decedent of Hi	spanic Origin? (Sp			merican Indian.				
9	fer d	þ	1 Never Married 2 🔀 Married	Armed Forces? 1 X Yes 2 ☐ No	If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, W	hite, etc.				
21215-0036	urs a tural	Completed	3 🗆 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates 1952–55	1 ☐ Yes 2 🏹 No	Specify:		Specify:	White				
15	72 hc 1 "na" Iedic	lg l	15. Decedent's Educa (Specify only highest grade c	ompleted) (Giv	cedent's Usual Occupa ve kind of work done d		king	16b. Kind of Busine	ss/Industry				
12	ithin iene.	ပ္ပ	Elementary/Secondary (0-12)	College (1-4 or 5+)	DO NOT use retired)  Carpenter			Constru	ction				
	Hyg othe	Be	17. Father's Name (First, Middle, Last)		Carpencer		ne (First, Middle, Ma		CCION				
Maryland	ge 1 and 2 should be filed within 72 hours after death with the Maryland to 7 Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	은	Ernest Millard Mon	coe mabry		Blanche		ia Midki	lff				
lan	should and N is ma	١,	19a. Informant's Name/Relationship (Type, I	Print) 19b. Ma	illing Address (Street a	and Number or Rur	al Route:Number, (	City or Town, State,	Zip Code)				
	and 2 Health em 27		June Mabry / wife		1 Highbord	Ct./Mou	nt Airy,	Maryland					
Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Rem	20b. Place of Dis	position (Name of rematory or other place	e)	Date 2	20c. Location - City	or Town, State				
ţi	it. Pag rtmen rtant: njury		4 Donation 5 Other (Specify)	Stauffer	r Cremator		/2011 F	rederick,	,Maryland				
Bal	permit. Page 1 a Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licenses	/ //	22. Name and Addres		8 E.R	idgeville	Blvd.				
			23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one ca	ons that caused the death. Do not e					21771 Approximate				
	Physician/	•,	Interval Between Onset and Death										
	Medical		1,5 4 GARS										
	Examiner		Commendation that are stated	Due to (or as a consequence of):									
	- ±	edical Examine	Sequentially list conditions, if any, leading to immediate true of the United Season of Injury	Due to (or as a consequence of):									
	cutec and trans	xan	that initiated events c										
_	death certificate be executed ne attending physician and ed for use as the burial-transit	alE	resulting in death) Last	Due to (or as a consequence of):									
760	cate b physi	edic	d										
89	Dertifi Dding Jse as	Z N	IF FEMALE: 23b. Was decedent pregnant 23c.	f yes, outcome of pregnancy				22d Date of	والمائية				
Box 687	eath o	Physician/M	in the past 12 months?		Ctopic pregnancy Other (specify)	y 		23d. Date of o Month	Day Year				
		hys	9 Unknown	Unknown			.,						
P.O.	requires that the death certific been signed by the attending p should be detached for use as	by	Part II. Other significant conditions contrib	uting to death but not resulting in the	underlying cause give	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?				
ds,	en sie	Completed					1 ☐ Yes	s 2 <b>/X</b> No 3 🗆	Probably 4 D Unknown				
00	law re nas be e 2 sh	nple					24a. Was an autopsy		autopsy findings available to completion of cause of				
Re	rsician: The law r s certificate has b director, page 2 s	Col					perform 1 \sum Yes 2	ed? death	? Yes 2 \( \subseteq \text{No} \)				
ta	ysician: is certific director,	Be	25. Was case referred to medical examiner?	ital:	26. Pla	ce of Death (Chec							
<u></u>	Phys	٠ ا	Yes 2 No	1 ☐ Inpatient 2 ☐ ER/Outpati 8a. Date of injury 28b. Time	ent 3 L DOA	4 U Nursing Ho		ce 6 Other (Sp	ecify)				
n c	ath. th. Afte e fune	cate	27. Manner of Death  17. Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury	work?	Yes 2 No	28d. Describe how	injury occurred					
isic	Atter	Certificate:	3 Suicide 6 Could not be	8e. Place of Injury - At home, farm, s					Rural Route Number,				
	To the Hospital within 24 hours To the Funeral   completely filled	Medical	29a. Certifier 1 Certifying Physician (Check 2 Medical Examiner: C	To the best of my knowledge, death on the basis of examination and/or inve	occurred at the time,	, date and place, a	nd due to the cause	e(s) and manner as	stated.				
	the thin 2 the fundamental the	Me	only one) 3 L Certifying Nurse Pra	ctitioner: To the best of my knowledg	e, death occurred at th	e time, date and pla	ace, and due to the	cause(s) and manner	r as stated.				
	<b>₽</b> ₹ <b>₽</b> 8		29b. Signature and title of certifier	Course un	29c. License	number <b>3176</b>	290	d. Date signed (Mor	nth, Day, Year)				
			30. Name and address of person who compl	ated course of death (the contract	Drint			110/	-0//				
	P		Brught M. D. Cont	red cause of death (Item 23a) (Type,	W. 8EVER	VTA 57	: fre	OERICA	MD 2(70)				
	Stat	е	31. Date filed (Mon (L Pay Yar) 4 2011	32. registrar's Signature	1		1						
	Registra	ır	777 0 7 2011	Ceneur B. G	Backer								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 13, 201 Physician/ 49320C 8:28 PM HEMCOMB Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LUNGE Baltimore washington Medical Cente Burni Glen Anne If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** (Month, Day, Year) 218.68.0388 1 M M 2 🗆 F Months Days Hours Min. Yrs. Director Usual Residence of Deced 28a-f show 10d. Inside City Limits 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b County 10c. City, Town or Location Director 1 Yes 2 No GADEN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 1749 NOTLES 21122 1.5.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces Black, White, etc. à 1 Never Married 2 Married 2 No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates Specify: WhITE Completed 3 Divorced 4 Divorced Newcomb, Joseph 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SEDAN SERVICE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Randolph HUTCHING 2018is 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7749 NOTLEY RO. PASADENA, JOANNE LYNN NEWCOMB MD.21122 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ARUNDE CREMATORY 11-15-11 4 ☐ Donation 5 ☐ Other (Specify) ODENTON, MD. 22. Name and Address of acility DAUGHERTY FUNERAL HOME 2601 MOUNTAIN RD. ABATEMAIND. 21122 23a. Part 1. Enter the discase, or some shock, or heart failure. List only of alloations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEPTIC SHOCK 2 4AA P disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner SMEEKS NUMBURY Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, CYRRHOSIS SECONDARY to HEPATITIS C AND 1 Yes 2 S No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an JOHOSSA autopsy performed? Yes 2 No page 2 death?
1 Yes 2 No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ပ 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 X Natural 5 Pending 2 Accident 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in by determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) OH was gried and would al D00e5+1A MONEWBER 13" 50 11

Registrar

301 HOSPITAL DRIVE, CLEW BURNIE, MD 20161

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OJBAG4412 BROCOMABIJIUD

. Date filed (Month, Day, Year) NOV 2 1 2011 11-08098 Anna Policarpio

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

inna Policarpio	State of Maryland / Department of Health and Mental Hyglene  1- For State  Certificate of Death  Reg. No. 2   1   2   7   2
Physician Medical Examine	
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 158 Continental Drive Elkton Cecil
Funeral Director	5. Social Security Number 213-98-3531 6. Sex 17. Age (In yrs. last birthday) 39 Yrs. 19 Hours
any	Usual Residence of Decedent  10a. State
Maryland 28a-f show d at once	MD Montgomery Silver Spring  1 Yes 2 X No  10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
death with the Maryland or items 23a or 28a-f sho must be notified at once	
nore, MD 21215-0036 sges I and 2 should be filed within 72 hours after nt of Health and Mental Hygiene.  f: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner.  To Be Commisted by	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Fidel C.Policarpio Belen Cruzin
ore, MD 21 ges 1 and 2 should 1 to f Health and Met : If item 27 is man ther traumatic ev	Belen Policarpio/Mother 3150 Beethoven way Silver Spring, Md20904
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tra	20a. Method of Disposition  1 Aburial 2 Cremation 3 Removal from State 4 Donation of Other Specification 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven  20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven  11/2/2011 Silver Spring, Md
Baltimo permit. Page Department of Important: injury or oth	21. Signatur of Funeral Server of Conseed PHYTE TYPA does of Frink ALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd. Silver Spring, Md20910
Physician Wedical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease a. Complications of Cerebral Palsy  Death
*{	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.
nsit Cyaminer	if any, leading to immediate Due to (or as a consequence of):  couse Friter Underlying Couse  (Disease or injury that initiated Couse Cous
and Cansit	events resulting in death) Last Due to (or as a consequence of):  d.
60, ate be executed hysician and e burial - transit	
Division of Vital Records, P.O. Box 68760,  Bospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.  Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial - transial Certification: To Be Committed by Physician/Medical F3	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year  4 Pregnant at time of death 5 Other (Specify)  9 Unknown
ires that the disperse of the detached the detached the Dhy Physical Physic	
(ecords, Fine law requires are has been sign age 2 should be or moleted	
of Vital Records, gr Physician: The law requir the truit certificate has been s neral director, page 2 should 1: To Be Completed.	
F Vital Rec Physician: The ar this certificate ral director, page To Be Con	25. Was case referred to medical examiner?  1 ✓ Yes 2 No
ion of tending Pt (cath. tor: After the funeral atton: T	
Division o spital or Attending rours after death. neral Director: Aft filled in by the func Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division To the Hospital or Attention within 24 hours after death within 24 hours after death completely filled in by the Medical Certificati	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
4 4 8	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  O.C.M.E.  October 29, 2011
	30. Name and address of person who completed cause of death (Item 23a)
-0/04	Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  31. Date filed (Menth, Day, Year), Day (Septimore)  22. Registrar's Signature
State Registra	NIN I TO THE METAL OF THE PROPERTY OF THE PROP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🔈 🗍 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 11:45 PM November 14, 2011 Hillary Haugh Price /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Hagerstown Golden Living Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 🖫 F 83 Yrs. 212-24-7293 May 1, 1928 Pennsylvania Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County ir than "natural", or items 23s or 28s-f show the Medical Experies must be notified at 1X Yes 2 □ No Smithsburg Maryland Washington Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21783 U.S.A.11 Blue Mountain Estates filed within 72 hours after death. Hygiene. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 

Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Home 12 Homemaker other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if them 27 is marked oth any injury or other treumatic event spice. Be Mary Belle Haugh William N. Henson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Daughter) 11 W. Water St. Smithsburg, Maryland 21783 Melissa A. Williams 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition November 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hagerstown, Maryland Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 18, 2011 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J.L. Davis Funeral Home MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 LAWIS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 14eow. Metasatu # Physician Carcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequential y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): physicien Completed by Physician/Medical attending I for use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) signed by the at d be detached to 1 ☐ Yes 2 ☐ No Ö 9 Unknown 9 Unknown Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown should ! 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy his certificete h I director, page 1 ☐ Yes 2 ☐ No 1 Yes 2 No of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ဥ this After the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Division Attending 1 Natural 2 ☐ Accident 5 Pending 1 Tes 2 No death. investigation the f by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) hours after ouneral Directly filled in by 4 Thomicide ö within 24 hours a

To the Funeral C

completely filled i To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 11-15-11 fros 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 368 mill street Hogstein 19021740 31. Date filed (Month, Day, Year)

NOV 2 1 2011 OSHAP1. 3. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:15ам Richard William Rumke October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Burtonsville Montgomery Sanctuary at Holy Cross If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗓 M 2 🗆 F Days Hours Min. 84 Ohio **Director** 291-22-0276 Usual Residence of Decedent or 28a-f show notified at filed within 72 hours after death with the Maryland all Hygiene. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o Funeral U.S.A. 20904 12801 Old Columbia Pike, #119 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No 1945-Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: Completed 3 Widowed 4 Divorced 1946 Caucasian the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) National Academy of College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Sciences Civil Engineer is marked other aumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental t Important: If item 27 is marked o any injury or other traumatic eve once. and Mental ဂ္ Clara Smith Henry C. Rumke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12801 Old Columbia Pike, #119, Silver Spring, MD 20904 Ethel Mae Rumke - Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) incoln Crematory 11/04/2011 | Brentwood, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD20904 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Phylician COPD Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed pub Cause (Disease or impute that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed A-Fib 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2 🗌 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Hospital Other: 2 No 1 Yes\_ မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5  $\square$  Pending work within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00069829 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smith Ave Baltenine MD Suite 203B

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RICKS Month DALLAS 0840AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** DLNEY MONTHOMERY MONTGOMERY GENERAL 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours (Month, Day, Year) 215-20-3616 **Director** 1 🛛 M 2 □ F 11/09/1926 MD 84 or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ul Hygiene. I other than "natural", or items 23a or vent, the Medical Examiner must be I Funeral 20904 U.S.A 531 Randolph Road, #315 B death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Yes, specify Cuban, Mexican, Puerto Rican, etc.) rmed Forces?
X Yes 2 \( \subseteq \text{No 1946-} Black White etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify. Completed 3 X Widowed 4 Divorced Black 1947 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) City of Rockville Dispatcher Government ulth and Mental Hygie 27 is marked other r traumatic event, til Be 17, Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ Frederick Ricks Sadie Lee of Health and Me fitem 27 is mark rother traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gayle Gray/daughter 7137 Oberlin Circle, Frederick, MD 21703 Baltimore, 20b. Place of Disposition (Name of cemeters crematory or other 20a. Method of Disposition 20c. Location - City or Town, State Department of I Important; If its any injury or of once. Gate of Heaven rematory or other place 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, MD 11/04/2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St. Rockville, MD 20850 23a. Part 1. Enter the disease or complic shock, or heart failure. List only one one that caused the death. enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ SHOCK disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Due to (or as a consequence of) Examin Transit PERIPHERAL ARTERIAL Due to (or as a consequence of) resulting in death) Last burialattending physician DIABETES Physician/Medical certificate be P.O. Box 68760 the 88 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) signed by the atte in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ON CHRONIC KIDNEY Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, page 2 No 2 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: Injury at 28d. Describe how injury occurred Natural 5 Pending work' 1 🗌 Yes 2 🗌 No 2 ☐ Accider 3 ☐ Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

State Registrar 3

29b. Signature and title of certified

OLUYEMISI

NOV 03 2011

31. Date filed (Month, Day, Year)

MD

SDawren, NED

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ADEWUNMI

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

OCTOBER 28, 2011

MONTGOMERY GENERAL HOSPITAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCT. 30, 2011 0501 Guadalupe Tabares Reynoso Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Takoma Park Montgomery Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 11/10/11/12/19/14/19 3 6 last birthday 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Mexico 229-53-3771 Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland event, the Medical Examiner must be notified at Director MD Prince George' Cheverly 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or Funeral 2343 Belle View Avenue 20785 Mexico permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Black, White, etc. White Armed Forces?
1 ☐ Yes 2 ☐ No à 1 Never Married 2 Married 1 X Yes 2 □ No Specify: Mexican Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Landscape worker Elementary Seconday (0-12) Landscape Be 17. Father's Name (First, Middle, Last)
Juan Tabares Jauregui 18. Mother's Name (First, Middle, Maiden Surname)
Aurora Reynoso Guzman ည injury or other traumatic 19a. Informant's Name/Relationship (Type, Print)

Juana Ayala/Friend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2343 Belle View Avenue Cheverly, Md. 20785 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State Pantsan Felipe 11/8/2011 Pate Atotonilco El Alto, Jalisco, Mexico 20b. Place of Disposition (Name of 4 Donation 5 Other (Specify) PHILIDAGE RIMALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 21. Signal vi & Furteral Servic 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ongestive disease or condition Medical resulting in death) Due to (or as & consequence of) Examiner Sequentially list conditions, if any, leading to immediate re attending physician and ed for use as the burial-transit Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) æ Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) Hospital 1 🗌 Yes 2 110 မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending 24 hours after death. Funeral Director: Af 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de

To the Funeral Directo

completed filled in by the 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Quertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 60100 MD 00

State Registrar 31. Date filed (Month, Day, Year)

NOV 03 2011

Almins

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Glenda Jean Sloned	1- For State	State of Maryl		nent of l		Mental H	_	20	11 3712		
Physician/	Registrar  1. Decedent's Name (First,	Middle,Last)					2. Date of Dea		3. Time of Death		
Medical Examiner			Jean Slone					r 12, 2011	1032 hrs		
	4a. Facility Name (if not ins 117 East Cecil Av	· -	umber)		. City, Town, or L North East	ocation of Death		4c. County of Death Cecil			
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. last b	irthday)	If Under 1 Year	If Under 24Hrs	_		9. Birthplace (State or		
Director	217-80-5594	1 M 2 X F	36	Yrs.	Months Days	Hours Min.	02/05	/1975	oreign Maryland Country)		
, and	Usual Residence of Deceder 10a. State 10b. Co		10c. City, Tow	m or Location	1				10d. Inside City Limits		
inw any		Cecil		th Eas				1 Y Yes 2 No			
the Maryland a nr 28a-f sh tified at once Director	10e. Street and Number	Jec II	NOT		10f. Zip Code		1	l 0g. Citizen of What	Tr.		
the Main of the Ma	117 East Ce	cil Avenue		i	2190	)1		United	l States		
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. raked other than "natural", nr items 23a nr 28a-f shnwent, the Medical Examiner must be notified at once. Be Completed by Funeral Director	11. Marital Status	12. Was De	ecedent Ever in U.S.		Decedent of Hispa	anic Origin? ( Sp		o- 14. Race - A	merican Indian, Black,		
r death v nr item must b	1 X Never Married 2	1 Yes	2 🗓 No	_	s, specify Cuban, I		Rican, etc.)	White, e			
rs after ural", niner	3 Widowed 4 15. Decedent's Education	Divorced If Yes, Give Ye or Dates:			es 2 X No Usual Occupatio		ork done	Specify: \ 16b. Kind of Busin	White		
5-0036 ed within 72 hour lygiene. the Medical Exatt che Medical Exatt Completed	Elementary/Secondary (0		(1-4 or 5+)		t of working life.			TOD. KING OF BUSHI	555/madatiy		
5-0036 led within 7 Hygiene. lother than the Medica	12			Wait	ress			Restau	ırant		
filed w Hygid d other	17. Father's Name (First, M				18			Maiden Surname)			
2121 ould be fi d Mental I s marked tic event, To Be	J. Glenn S1  19a. Informant's Name/Rela		T <sub>1</sub>	9b. Mailing A	Address (Street :	Earlett		OT mber, City or Town, S	State Zin Code)		
AD 2 shorth and 2 27 is imatic	J. Glenn S1				•				21901		
Te, Nand I and Health	20a. Method of Disposition  1 Burial 2 X Crem		20b. Place		on (Name of ceme	etery.	Date ember	20c, Location - Ci	y or Town, State		
Pages lent of traff. It at: It	4 Donation 5 Oth		TOTA State	Ferris	& Co In	c.   15.	2011	West	Chester, PA		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or nither traumatic event, the Medical Examiner. To Be Completed by F	21. Sig Sture of Funeral Se			22. Na	me and Address o	of Facility Hi	cks Hom	ne for Fun	erals, P.A.		
	23a. Part I. Enter the diseas	e or complications that	cka)					Elkton,	MD 21921 Approximate Interval		
Physician // /Medical	failure. List only one of	ause on each line.			_				Between Onset and		
Txaminer	Immediate Cause (Final dis or condition resulting in dea		e, Oxycodor a consequence of):	ne, Met	nadone a	na Alpra	azoıam	Intoxicat	ion		
	Sequentially list conditions,										
in a	if any, leading to immediate cause. Enter Underlying C	ause	a consequence of):								
ted Insit	(Disease or injury that initial events resulting in death)	ted -	a consequence of):								
be executed cician and curial - transit	X UNPENDED	AMENDED	23a,27,28a	a-f,per	me,g92	1 11-22-	-11 sm				
	IF FEMALE: 23b. Was decedent pregnan	23d. Date of del									
k 68 n certii cending use as	past 12 months?	4 Preg	nant at time of death	- =	death 3 _ r (Specify)	Ectopic pregna	ncy	Month	Day Year		
Box 68760 e death certificate the attending physed for use as the bhysician/Me	1 Yes 2 No 9	, lactions									
Vital Records, P.O. Box 68760 hysician: The law requires that the death certificate this certificate has been signed by the attending physidirector, page 2 should be detached for use as the but to Be Completed by Physician/Me	Part II. Other significant co	onditions contributing	to death but not resulti	ing in the und	derlying cause giv	en in Part I.			e to the cause of death?  Probably 4 V Unknown		
duires quires uld be uld be							24a. Was		re autopsy findings available		
Records, The law requires ficate has been sign, page 2 should be							autop perfo	osy prior deal	r to completion of cause of		
Rei ificate Con	05 10/	adian!			00 Di-	f Death (Observe	1 Yes		Yes 2 No		
Vital Rec ysician: The I his certificate I director, page	25. Was case referred to me examiner?  1 ✓ Yes 2 No	Hospital:	Inpatient 2 ER/	Outpatient		f Death (Check of ther Nursing		Residence 6 🗸	Other: Scene		
n of Viding Phys L. After this funeral di	27. Manner of Death	28a. Date		. Time of Inju		at Work?	28d. Describe	how injury occurred	<del></del>		
ion tendir eath. for: A the fu	1 Natural 5	Decident I may be		10:06	am 1 Ye	s 2 X No	subject nedicin	: took dru es	gs and		
Division of Vital Records, P.O. spital or Attending Physician: The law requires that th tours after death.  The spital or Attending Physician: The law requires that the tours after death.  The spital pirector, page 2 should be detached by the filled in by the funeral director, page 2 should be detached for the funeral director, page 2 should be detached by Perfification: To Be Completed by P	3 Suicide 6 X 4 Homicide		ce of Injury - At home, Res	farm, street,	•	Iding, etc.	28f. Location ( or Town, S North	Street and Number of State) 17 Eas East, Md.	r Rural Route Number, City t Cecil Ave.		
Division of Vital Records, P.O. Box 6876( To the Unspital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the beached control of the Complete of the	( orroon only	ng Physician: To the be I Examiner: On the basis and manner	of examination and/or								
F 3 F 3	29b. Signature and title of co		otatou.		29c. License i	number		29d. Date signed	(Month, Day, Year)		
	anes				O.C.M	.E.		November 13	, 2011		
1	30. Name and address of pe		,	,	oro Ctro-t D	oltimore ACD	1 21222	•			
State		Assistant Medical	egistrar's Signature	vv. baitim	ore street, B	ailinore, ML	21223				
Registrar	31. Date filed (Month, Day, )	111 Benera	A ba	Kel							
DHMH 17 Rev 1/2001 OCME 2006		OCME	0	RIGINAL							

	Please	-		n <b>Black I</b> I and / Depa					•		egible.			
For State Registrar		State Of	iviaiyia		tificat			and iv	, ,	Reg. No.	2011	37128		
Dhunisian/	Carol Hildegard Straus 10/24/2011										Year	3. Time of Death 1:55 A M		
Examiner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of l  Manor Care Potomac  Montgo										,			
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. E										9. Birth	place (State or Foreign		
<b>Director</b> 052–18–7138	Usual Residence of Decedent 1 □ M 2 ☑ F 104 Yrs.									(Month, Day, Year) Country) 10/27/1906 German				
pust to 10a. State 10b.	. County		10c. 0	City, Town or Lo	cation							10d. Inside City Limits		
MD 10a. State 10b.	Montgom	ery	P	otomac	10f. Zip	Code			1	10 000		1 🔀 Yes 2 □ No		
10714 Poton 11. Marital Status	mac Ten	nis Lan	e			.0854			ļ	l0g. Citizen of What Country?  USA				
The death of the status of the		12. Was Deced Armed Ford	ent Ever in l		Vas Dece	lent of His	spanic Orio	gin? (Spe , Puerto	cify Yes or No- Rican, etc.)	14.	Race - Ameri Black, White,			
within 72 hours after of giene.  Within 72 hours after of giene.  The Medical Examiration of the Medic	1 Never Married 2 Married 1 Tyes 2 No 3 X Widowed 4 Divorced Year or Dates.						Specify:			Spe	ecify: Whi	te		
if thin 72 hours at least.  Ithe Medical Exemple (Specify or Specify or Elementary/Secondary)  Solution:  (The Medical Exemple (Specify or Elementary/Secondary)	Decedent's Ed only highest grad			16a. Dece	kind of wo	rk done d		of worki	ng	16b. Kind	6b. Kind of Business/Industry			
State of the state	y (0-12)	College (1-4	l or 5+)		o <i>notu</i> se e <b>make</b>	,				Own	Home	lome		
17. Father's Name (First, M				100					e (First, Middle, I	Maiden Surr	name)			
Rarl Micha		oe, Print)		19b. Mailir	na Address	(Street a		_	othmann I Route Number	City or Toy	vn. State. Zio	Code)		
Thomas M. S		- Steps	on	Τ .	•	,			evada C	,				
Debartment of Health and Merital Status  To Be Construct Page 1 and 2 should be filed within T2 hours after death with the Maryland Debartment of Health and Mental Hygiene. In Mortants If item 27 is marked other transmatic event, if them edical Examiner must be notified at any injury or other transmatic event, the Medical Examiner must be notified at 15.  Copecify or Elementary/Secondary  17. Father's Name (First, Marcha 19a. Informant's Name/Resource 19a. Informant's Name/Resource 19a. Information 5 □ 20a. Method of Disposition 1 □ Burial 2 ☑ Cre 4 □ Donation 5 □ 21. Signature of Funeral Secondary	emation 3 🗌		State	. Place of Dispo cemetery, crer	natory or o	ther place			Date		ion - City or T s Chur			
4 Donation 5 Day 21. Signature of Funeral S			IN &	ational	. Name an	d Addres	s of Facilit	v Dan	2011 zansky-	Coldb	ora Mo	a Momortal		
VICTORIA	Sean		1016	11 II	170 R	ockv	ille	Pike	Rocky	ille,	MD 20	852		
23a. Part 1. Enter the dis shock, or heart failu Immediate Cause (Final disease or condition	rease, or comp re. List only on	e cause on eac	used the de h line. t Fai]		er the mod	e of dying	g, such as	cardiac c	r respiratory arr	est,		Approximate Interval Between Onset and Death		
Medical resulting in death)  Examiner	Due to (or as a consequence of):											Vocasa		
Sequentially list condition if any, leading to immedia cause. Enter Underlying	ns,	b. —	i as a const									Years		
	Cause Disease or injury that initiated events tresulting in death) Last  Due to (or as a consequence of):													
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eath certificate beath certificate by the state of the st		23c. If yes, outc	ama of prog	nanov										
The law requires that the death certificate by the asset has been signed by the attending physical page 2 should be detached for use as the representation of the last of the	ns?	1 Live B	irth 2 ☐ Fe ant at time o	etal death 3		Ectopic pregnancy Other (specify)					23d. Date of delivery  Month Day Year			
that the defactor of the defac		9 Unkno		resulting in the I	nderlying	rause niv	en in Part I		220 Did to	haasa uga r	contribute to t	he cause of death?		
Part II. Other significant of the significant of th												bably 4 🔀 Unknown		
Division of Vital Records,  s affer death.  s affer death.  al Director. After this certificate has been signed in by the funeral director page 2 should be examiners.  To Dementia  Advanced A  25. Mas case referred to use a signed of a should be examiners.  To Dementia  Advanced A  26. Manuer of Death  To Dementia  Advanced A  27. Manuer of Death  To Dementia  Advanced A  28. Mold A  29. Mold A  20.									24a. Was a		4b. Were auto	opsy findings available ompletion of cause of		
Advanced A									perfor 1 Yes	ormed? death?				
Vital No. 1   Vital No. 2   Vi	1.0	lospital:	patient 2 [	☐ ER/Outpatier	nt 3 🗆 D0	Othe	r: 4 😿 Nu		me 5 Resid	ence 6 $\square$	Other (Specif	y)		
27. Manner of Death	Pending	28a. Date of (Month	f injury , Day, Year)	28b. Time of injury		8c. Injury work?	?		28d. Describe h	w injury oc	curred			
or Attending P or Attending P or Attending P or Attending P of Attending P or Att	Investigation Could not be determined	28e. Place o		home, farm, str	M eet, factory		Yes 2 🗆				ımber or Rura	l Route Number,		
Div ontal or outs aftivars aft			g, etc. (Spec						City or Tow					
유 전 교 형 (Check 2 🗆 M	tion and/or invest	ledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  n and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							ause(s) and manner stated.					
29b. Signature and title of	f certifier	. 11				. License					gned (Month,	Day, Year)		
30. Name and address of	person who co	ompleted cause	of death (Its	em 23a) (Type F		31319	,			10/24	4/2011			
Loreto S. A.	lbiol,	M.D. 8	3218 W	isconsi	n Ave	nue,	Sui	te 3	05, Bet1	nesda,	, MD 20	0814		
State 31. Date filed (Month, Day, Registrar	y, Year) 3 2011	72. Reg	gistrar's Sigr	pature pau	to.									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10/25 11 Carol Smvers 8:35 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Casey House Rockville Montgomery 8. Date of Birth (Month, Day, Year 6/2/1930 Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Hours Country) Wash Director 577-36-8806 81 Usual Residence of Decedent show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery 1X Yes 2 ☐ No Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral USA 20895 11411 Orleans Way death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specity Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.' Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give within 72 hours after altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 3 X Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If Hem 27 is marked any injury or other traumatin enginee. ၉ Elwood H. Seal Virginia Swaim Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Flanders Daughter 4504 Clermont PL P.O. Box 379 Garrett Park MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Rock Creek Cemetery 11/2/11 Washington DC 21. Signature of Funeral Service License 22. Name and Address of Facility Joseph Gawler's Sons 5130 Wisconsin Ave. NW Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Advanced Dementia Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir that initiated events resulting in death) Last Due to (or as a consequence of): as the burial physician Physician/Medical certificate be Box 68760 use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 🕱 No ò Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown be detached the P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, UTI ( urinary tract infection ) Completed 1 Yes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of death? Acute encephalopathy has page 2 autopsy performe Hypotension Yes 2 X No 1 🗌 Yes the Hospital or Attending Physician: 25. Was case referred to medical mpleted filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 € Other (Specify) Hospice this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debrah Miller, CRNP

Registrar's Signati

1355 Piccard DR Suite 100 Rockville MD 20850

03 2011

R143201

Registrar

DHMH 17 Rev 7/2009

State

Mira

Fazli

Rockville

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 22, 2011 Salvatore William Savarino 17:50 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bethesda Montgomery Suburban Hospital If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Ye Jan. 29, Months Year Hours **Director** 051-22-8019 1 🛛 M 2 🗆 F 79 1932 Ohio Usual Residence of Dece or 28a-f show 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director MD Montgomery Montgomery Village 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 23a 18602-1 Walkers Choice Road 20886 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ed other than "natural", or ite event, the Medical Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1858 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 X Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygien Director of Gov. Contracting Communications Be 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ferdinand Savarino Cecilia LoTempio traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Peter N. Savarino/Son 2301 N. Trenton St. Arlington, Virginia 22207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State φ 1 Durial 2 X Cremation 3 X Removal from State permit. Page Department o Important: If any injury or injury or National Crematory 10/29/2011 Falls Church, Virginia 4 Donation 5 Other (Specify) 22. Name and Address dward Sagell Funeral Direction, Inc. Signature of Funeral Service Licensee 1091 Rockville Pike, Rockville, Maryland 20852 maguentus mo1597 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 7 2nsettand Teath Physician/ Gastrointestinal Bleeding disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and -- Tansit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year Yes 2 No 1 Yes 2 L 9 Unknown the 9 Unknown á signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Myelomonocytic Leukemia 1 Tes 2 No 3 Probably 4 Unknown been signated Completed Acute and Chronic Renal Insufficiency 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy certificate ha performed? Yes 2 X Hospital or Attending Physician: The Anemia 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes ျှ 2 XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signatu nd title of cer 29d. Date signed (Month, Day, Year) 10 729675 October 27, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

Ralph V. Boccia, MD

NOV 03 2011

31. Date filed (Month, Day, Year

32. Registrar's Signature

6420 Rockledge Drive, Bethesda, Maryland 20817

am Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible In 11/4/11 State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11033 PM 201 Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗖 M 2 🗆 F 578-94-464 WASIFINGTON BC Director or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at Director FREDERICK FRED ERICK 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral items 23a BLACK DUCK 6720 USA 21703 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian. Armed Forces?
1 Yes 2 No Black, White, etc. or, 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 Ø No Specify: If Yes, Give "natural", 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event the Man Elementary/Seconday (0-12) College (1-4 or 5+) HOSPITAL STERILIZATION TLCH. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ SEARS SWORD OUISE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) REDERICK MD 21703 SEARS BLACK DUCK CT SHARMA (WIFE) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town State Smithsburg, Maryland metery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cremator NOV. 7, 2011 Smithsburg 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ARY L . ROLLINS Kollen FREDERICK WEST SOURT ST Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) # Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death Other (specify) 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed Yes 2 2 100 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X**No 1 🗌 Yes ျ Impatient 2 ER/Outpatient 3 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Tes 2 🗆 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title ofcertifie 29d. Date signed (Month, Day, Year) 101100 S 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore outh Greene

Registrar

State

Box 68760

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10/28/2011 JEANETTE DOROTHY THOMAS 8:30 a M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Pleasant View Nursing Home Mt. Airy Carroll Age (In yrs. las If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 212-24-3188 Days 1 M 2 1 1 F 10720/1911 **Director** Usual Residence of Decedent show 10a. State the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 ☐ No Mount Airy MD Carrol] 10e. Street and Number ö 10f. Zip Code 10g, Citizen of What Country? pe ms 23a must be Funeral 4101 Old National Pike 21771 U.S.A permit. Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. "natural", or ite Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Specify: Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ed other than ' Elementary (Seconday (0-12) College (1-4 or 5+) Housekeeping Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked of r other traumatic ever Winfield Parker ဂ Virginia Dorsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 611 Cranberry Lane, Westminster, MD 21157 Carl V. Dorsey/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ē <u>=</u> ₽ 1 Burial 2 ☐ Cremation 3 ☐ Removal from Si Department of Important: If any injury or Bushey Park 11/3/2011 Glenwood, MD 4 Denation 5 Other (Specify) 21. Signa La of Funeral Service L Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the of at Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Due to (or as a consequence of): Medical resulting in death) **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Dementia that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Year signed by the a 🗌 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown need 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 2 No 1 Tes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 XNo Hospital 1 Yes Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA After this 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D57574 11/1/2011

DHMH 17 Rev 7/2009

State

Registrar

7133 Mill Run Drive, Derwood, MD 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ahmed Heshmat, MD,

NOV 03 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 9:43 PM Lois Ann Trumbore 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci Elkton Care & Rehabilitation If Under 24 Hrs. . Social Security Number 8. Date of Birth (Month, Day, Year) 7/20/1939 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1 □ M 2 🖾 F Hours Director 206-30-2825 72 PA Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Ceci1 Rising Sun MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1040 Ebenezer Church Road 21911 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces 0, Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 X No Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: "natural", Completed 3 Divorced 4 Divorced White Year or Dates ge 1 and 2 should be filed within 72 hour nt of Health and Mental Hygiene.

It item 27 is marked other than "natur or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Helen Nagy Louis Nagy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ebenezer Church Road, Rising Sun, MD 21911 1040 Merr W. Trumbore - husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of I-Important: If ite any injury or ot Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park Cemetery 11/9/2011 Bethlehem, PA uneral Se vice Licens 22. Name and Address of Facility R.T.Foard Funeral HOme, PA Queen Street, Rising Sun, MD 21911 111S. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Stase Renal disease Immediate Cause (Final Onset and Death Physician, disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir executed Cause (Disease or iinjury that initiated events and tran Due to (or as a consequence of): resulting in death) Last attending physician at for use as the burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

Q Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 1 Yes 2 ed by the detached Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an cate has t page 2 st autopsy death' After this certificate funeral director, pag 1 ☐ Yes 2 ☐ No 2 X No ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 🔼 No ျှ 1 Yes 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No s after death.

I Director: After din by the fundament 2 Accident 3 Suicide Investigation Μ 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours af To the Funeral Di completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check з 🗆 Aprtifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and titi 29d. Date signed (Month, Day, Year, D0062190 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUGUSTINE HERMAN HWY, SUITEA, SHAHNAWAZ KHAN 12533

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day\_ Physician/ Graham Taylor SR. 8:03pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospice at the isbury OMICO . Age (In yrs. last birthday) 97 Yrs. 9. Birthplace (State or Foreign Country) NC. 8. Date of Birth (Month, Day, **Funeral** 214-01-2034 Director 18,1914 Aug. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Princess Anne MD. Somerset 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26725 Mt. Vernon Rd. 21853 United States 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Armed Forces? 1942 1 Yes 2 No 1946 If Yes, Give 1946 or i Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 1946 "natural", 3 XWidowed 4 ☐ Divorced Year or Dates iny injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) oermit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Transportation <u>Barge Captain</u> Be 18. Mother's Name (First, Middle, Maiden Surname)
Mary Edith Chadwick Taylor 17. Father's Name (First, Middle, Last) James W. Taylor <sup>19a.</sup> Informant's Name/Relationship *(Type, Print)* Sharon Fitzgerald —— Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Staham 101 Coulbourn Dr. Salisbury, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-03-2011 Asbury U. M. Cemetery Mt. Vernon, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, Md. 21853 art 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nmediate Cause (Final Onset and Death Physician/ DIOMYO disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Month Year Pregnant at time of death signed by the a 9 Unknown P.O. Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably Unknown should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b lirector, page 2 s autopsy perform 1 Yes Division of Vital 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 2 No 1 Yes 임 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this After this funeral of 27. Manner of Death Certificate: Natural 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury 5 Pending Accident 1 Yes 2 🗌 No within 24 hours after death

To the Funeral Director: A

completed filled in by the f Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Gertifying Nurse Practioner: To the best of my knowledge, death. at the time data and of 29b. Signature and title of certifie 29d. Date signed, (Month, Day, Year) D0058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 104 6 HULAW WD 2/80L . Date filed (Month, Day, Year) State Registrar

Physicia /Medica Examine

Funeral Director

	State of Maryland /			nd Mer	ntal Hygiei	ne 🔾 🤇	112	27	120				
_	1 - State Registrar	Cert	ificate of Death		Reg.	No. 2		31	130				
1	1. Decedent's Name (First, Middle, Last)					Day	Year	3. Time of					
ı	EDWIN WHITE  4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of D		ovember	11 . 4c. County	2011	4:14	a. "				
r				Jeath									
	19804 Davis Hill Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last b		Rawlings If Under 1 Year   If Under 24		Date of Birth		legan  9. Birthp	lace (State o	r Foreign				
	466-46-4015 1 M 2□ F 82	Yrs.	Months Days Hours N		(Month, Day, Yeller 27,		Cour	oit, M	Ι				
	Usual Residence of Decedent												
_	10a. State 10b. County 10c. City, Tox	wn or Loca	ation				1	0d. Inside Cit 1 ☐ Yes					
2		awlir							2 [A] INO				
5	10e. Street and Number		10f. Zip Code		10g.	Citizen of V		ntry?					
ruilerai Director	19804 Davis Hill Drive	10.14	21557	on /Connife	Van or No		SA Amorio	an Indian,					
בות בות	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	IS. VV.	as Decedent of Hispanic Origin' Yes, specify Cuban, Mexican, Pt	Puerto Rica	an, etc.)		ck, White,						
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 [	□Yes 2 No Specify:			Specify	/: W	Mite					
completed by	15. Decedent's Education 16.	a. Decede	nt's Usual Occupation		16b	Kind of Bu	usiness/Inc	dustry					
5	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life. Do	ind of work done during most of O NOT use retired)	r working									
5	8	Ca	rpenter			Home		ding					
מ	17. Father's Name (First, Middle, Last)				irst, Middle, Maic		ne)						
2	Dawson White				Cunningl								
			Address (Street and Number of		•		State, Zip	Code)					
4			Box 313 Rawlin	ngs,		Location -	City or To	wn State					
İ	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	tery, crema	nov	v. 16		Location -	City of To	WII, State					
	4 □ Donation 5 □ Other (Specify) Mt. Olivet Cemetery 2011 Amboy, WV  21. Signature of Funeral Service Licensee 22. Name and Address of Facility Smith Funeral Home												
	21. Signature of Funeral Service Licensee		•					_					
	23a. Part 1. Enter the disease, or complications that caused the death. Do		35 S. Main Stre		Keyser	, WV	2672	Approximate					
	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final												
-1	disease or condition resulting in death)  a. Due to or as a consequence	-											
	bue to tot as a consequence												
<u> </u>	If any, leading to immediate  Due to (or as a consequence)												
Fyallille	cause. Enter Underlying Cause (Disease or injury that initiated events c												
	resulting in death) Last Due to (or as a consequence	e of):											
an least	d												
	IF FEMALE:						1 2 2		- 17				
3	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy				te of delive	*	'ear				
III yalcıdırı	1 Yes 2 No 4 Pregnant at time of death	5 🗆	Other (specify)				,,,,,,	Day .	O GI				
	Part II. Other significant conditions contributing to death but not resulting	in the und	terlying cause given in Part I.		23e. Did tobaco	o use cont	ribute to th	ne cause of de	eath?				
completed by	g a same a same a same a same a same a same a same a same a same a same a same a same a same a same a same a s	,	5.7.1.g		1 □ Yes			ably 4∏ L					
				- 1				====					
2				-	24a. Was an autopsy performed		vvere auto prior to co death?	psy findings a mpletion of ca	ause of				
	25. Was case referred to medical				1 ☐ Yes 2 🔯	No	1 ☐ Yes	2 No					
3	examiner?	D d d d.	Other:		heck only one)								
2	27. Manner of Death 28a. Date of Injury 28b.	. Time of	28c. Injury at Work?		5 X Residence . Describe how in			<u>y)</u>					
	1 Matural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	Injury	Work? M 1 ☐ Yes 2 ☐ No	,		•							
	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stree	et, factory, office	28f.	Location (Street	and Numb	er or Rura	al Route Numi	ber,				
	4   normale				City or Town, Si	are)							
medical cel misanoni.	29a. Certifier  (Check only  2 Medical Examiner: On the basis of examination a	ge, death	occurred at the time, date and p	place, and	I due to the caus	e(s) and m	anner as s	stated.					
3	(Check only one) 2 ☐ Medical Examiner: On the basis of examination a and manner stated.	and/or inve	sugation, in my opinion, death o	occurred	at the time, date	and place,	and due to	ne cause(s)	' 				
	29b. Signature and title of certifier		29c. License number		29d.	Date signe	d (Month,	Day, Year)					
-	· Chromm	2-2.	1416	WI		11-10	1-61						
Ì	30. Name and address of person who completed cause of death (Item 23a	ı) (Type, P	•										
	Allen Kunkel, M.D. P.O. Box	1019	Petersburg,	, WV	26847								
	31. Date filed (Month, Day, Year)  NOV 2 1 2011  32. Registrar's Signature	a Man	,										
	THUT ~ I CULL ( PARKUTE) IN 1884												

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene per me, g921,11/18/2011dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ October 25 WILLIS В. WOOD 20ÎÎ 8:40 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mallard Bay Care Center Dorchester Cambridge Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 DXM 2 DF Director 274-28-8736 02/17/1926 OHTŐ Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director CAMBRIDGE MD DORCHESTER 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNIT #300 520 GLENBURN AVE., MALLARD BAY Funeral 21613 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.). 14 Race - American Indian Black, White, etc. Yes 2 No Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) TRANSPORTATION BUS DRIVER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ ELIAS K. WOOD VESTA HACKWORTH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BOX 142, ROYAL, MD 21662 JANELLE ALLEN - DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Kemoval from State 4 Donation 5 Other (Specify) DEL.VET.MEM. CEM. 11-2-2011 MILLSBORO, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BERRY-SHORT FUNERAL HOME 23a. Part 1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 119 NW FRONT ST., MILFORD, DE 19963 Interval Between Onset and Death Sub-arachnoid hemowher Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAL attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 Live Birth 4 Pregnant 9 Unknown Month Pregnant at time of death Day Year 1 Yes 2 9 Unknown 2 No the P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 10 3 Probably 4 Unknown has been signed to should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed' certificate Yes 2 INO Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 X Yes Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28h. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral Hospital or Attending 24 hours after death. 1 Natural 5 Pending Accident 1 Yes 2 No Investigation Suicide 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 503 BYRN CAMBRIDGE MA 26613 NOMM TIMNUY

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

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	1	For State Registrar			State o	of Mai	rylan		artmer <i>rtificat</i>			and N	lental Hy	gien Reg. N		Ш	3	7138
Physician/ Medical	Decedent's Name (First, Middle, Last)  Mary Eleanor Walker										2. Date of Death 3. Time of Death October 31, 2011 6:37 P							
Examiner	4a. Facility Name (if not institution, give street and number)  Montgomery General Hospital									Town, or Diney	Location (	of Death				. County of Death Iontgomery		
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 579−60−1143 1 □ M 2 🏋 F 96 Yrs.							If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	y, Year,	y, Year) Coun			te or Foreign	
		Usual Residence of Decedent								<u> </u>			May 4,	15	15 Washington, DC 10d. Inside City Limits			
leath with the Maryland items 23a or 28a-f shoer must be notified at Funeral Director	M	Iaryland De. Street and Num	Montg	omery	y		Si	lver S	pring					10- (	Oltizen of W	/hat Cau		Yes 2 X No
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ter o, or by		. Marital Status  1 Never Marri	ied 2 ☐ Mari	12.	Was Dece Armed For 1 Yes If Yes, Giv Year or Da	edent Eve rces? 2 XN			Was Dece	dent of His	spanic Ori n, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)		14. Race - American Indian, Black, White, etc.  Specify: White			9
ithin 72 hours af iene. r than "natural" the Medical Exa Completed		15. Decedent's Education (Specify only highest grade completed) (Given Stephenson (G								al Occupa rk done d e retired)	ation uring mos	t of work	ing	16b.	Kind of Bu		,	
Hygien other the ent, the Be Co					- <del>+</del> C	· ·		Tea	cher						Educ		on	
uld be filed I Mental H narked of natic ever		r.Father's Name (F Charles J	J. Walk	er							Ma	ry E	e (First, Middle, • Table	r				
nd 2 shoi ealth and m 27 is n	F	9a. Informant's Na <b>Peter C.</b>	Van He			orne	y		-				ington,				Code)	
Page 1 and pent of Hint: If itel	20	a. Method of Disp 1 ∰ Burial 2/[ 4 ☐ Donation	Cremation		noval from	State	CE	lace of Dispo emetery, crea Olive	natory or c	ther place	e) ]	Nove			Location - hingt			÷
permit. Departn Importa any inju	2	1. Signature of Fur	neral Service L	icensee	_			F2 50	alicis 0 Uni	d Addres	Coll ity	ĭns Blvd	Funeral	Ho Sil	me, I ver S	nc. prim	ng, M	D 20901
Physician/	li c	3a. Part 1. Enter the shock, or hear mmediate Cause (lisease or condition)	rt failure. List o Final				he death	n. Do not ent	er the mod	le of dying	, such as	cardiac o	or respiratory ar	rest,				mate Between nd Death
Medical Examiner	resulting in death)  Sequentially list conditions,																	
kecuted and all transit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a consequence of):  Condition Vosculor Disease  Condition Vosculor Disease																	
be executed sician and surial-transit cal Examil																		
ificate ng phy as the	IE.	FEMALE:		T														-
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trapsity.  Medical Certificate: To Be Completed by Physician/Medical Exam		Bb. Was decedent in the past 12 r 1 Yes 2 9 Unknown	months? No		23c. If yes, outcome of pregnancy  1  Live Birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)  Month Day Ye									Year				
signed by Id be deta	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I.										_							
sician: The law requ certificate has been director, page 2 shou Be Complete				/									24a. Was autoj perfo	psy ormed3	P	rior to co eath?	ompletion	gs available of cause of
ertificate ector, pa Be Co	25	. Was case referre	ed to nedical						_	26. Pla	ice of Dea	th (Check	1 L Yes	2	No 1	∐ Yes	2 🗌 No	
hysici his cer Il direc			No	Hosp	oital: 1 🗌	Inpatien	t 2 🗷	ER/Outpatie	nt 3 🗆 D	Othe	r: 4 🗆 Nı	ursing Ho	me 5 Resid	dence	6 🗌 Othe	r (Specif	y)	
To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page ()  Medical Certificate: To Be Com	27	7. Manner of Death 1 Natural 2 Accident	5 Pendir Investig	gation	28a. Date (Mon:	of injury th, Day, 1		28b. Time o injury	f M	8c. Injury work			28d. Describe h	now inj	ury occurre	d		
tal or Att rs after d al Direct led in by		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)							eet, factor			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
he Hospital in 24 hours he Funeral ipletely filled	2	(Check 2 only one) 3	Medical E	xaminer: Nurse Pr	On the bas	sis of exa	mination	and/or inves	tigation, in	my opinio	n, death o	ccurred at	nd due to the ca the time, date a ace, and due to t	and pla	ce, and due	to the ca	ause(s) and	manner stated.
lor con d	29	Bb. Signature and	title/b/ certifier		no				290	License	number	6		29d. [	Date signed	(Month,	Day, Year)	1
	30	Mame and addre	ess of person	who comp	leted caus	se of dea	th (Item	23a) (Type,	Print) N	110	1) (	Ine	Y MI	1 6	1083	2		
State Registrar	31	. Date filed (Month	h, <i>Day</i> , Year)	2011	37 R	egistrar's	s Signat	pre fa	المدين	7								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 28, 2011 3:26P M Cyrus DeWitt Weddle Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Frederick 491 Carrollton Drive Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Davs Hours Min. Feb. 19 Year 1922 Maryland 89 Director 216-32-0684 Usual Residence of Decedent Show or 28a-f shov notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rral", or items 23a or Examiner must be Funeral 21701 United States 491 Carrollton Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White "natural" 3 ₩ Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6 Farmer Agriculture permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 9 Ethel Gurley Baxter Weddle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6604 Linganore Rd., Frederick, MD 21701 Brian Weddle / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State cemetery, crematory or other place) Nov 2011 Frederick, Maryland Resthaven Crematory 4 Donation 5 1 Other 21. Signatur Fureral Servi 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. Frederick, MD 21701 9501 Catoctin Mountain Hwy. Frederick, Part 1. Enter the disease, shock, or heart failure. Ust rediate Cause (Final implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Approximate Interval Between Immediate Cause (Final 12 yrs. **Physician** ASCVD disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Atrial Fibrillation 12 yrs. Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Enter Under attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy certificate 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medica director. 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ္ခ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 the funeral After t within 24 hours after death To the Funeral Director: A completed filled in by

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Medical

Accident

3 29b. Signature and title of certifi

Suicide

4 Homicide

29a. Certifier (Check only one)

State Registrar

Sut -9 Ne Year) 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Investigation 6 Could not be

determined

32. Registrar's Signature

ank

43-

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying flurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

FREDERZICU

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MD

29d. Date signed (Month, Day, Year)

2011

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

io MEMOCA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23a per MD FCHD TM 11/4/11 to State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 30 October 20°1′1 5:18a James S. Young III Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick 603 Twilight Terrace Court Mt. Airy Social Security Number . Age (In yrs. last birthday) If Under Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Hours Min (Month, Day, Year) **Director** 063-26-6432 1 **X** M 2 □ F Yrs 80 Dec. 9, 1930 New York Usual Residence of Deced 28a-f show within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🗓 Yes 2 🗌 No Maryland Frederick Mt. Airy 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 603 Twilight Terrace Court 21771 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian the Medical Examiner Armed Forces?
1 

Yes 2 □ No Black White etc. ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Korean 1 ☐ Yes 2 X No Specify: "natural", Specify: Completed 3 Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Professor Music Education permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event; Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mildred Ireland James S. Young Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 603 Twilight Terrace Court, Mt. Airy, MD 21771 Christina M. Young/ Wife 20a. Method of Disposition 20b, Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 🗷 Cremation 3 D Removal from State cemetery, crematory or other place) Stauffer Crematory Inc.  $^{11/2/11}$ Frederick, Maryland. 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Stauffer Funeral Homes P. A.
1621 Opossumtown Pike, Frederick, Maryland 21702 Signature 4 ral Service Insee that / aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Probable Myocardial Infarction Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year 2 No be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3/ Probably 4 ☐ Unknown samid 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 Yes 2 No 1 Yes 2 No MOYN funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? s after death. 2 🔲 No the f 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D Medical 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completely (Check 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

1021

29b. Signature and title of certifier

31. Date filed (Morth, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signatur

LELLA

Griffin MD,

4 2011

29c. License number

302 South Main Street, Mt. Airy, Maryland 21771.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ Month Nancy Irene Arnone :50 P Nov. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1602 Brisbane Street Silver Spring Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign **Director** 220-60-4557 1 🗆 M 2 🕱 F 59 Mar 26, 1952 Washington DC Usual Residence of Decedent 28a-f show 10b. County with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1602 Brisbane Street 20902 USA items death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 0 þ 1 Never Married 2X Married 3altimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2X No Specify. Specify: White "natural" Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+ the Property Manager Real Estate traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I William G. McNeal Page 1 and 2 should be Loretta Elizabeth Overath 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health Robert S. Arnone/husband 1602 Brisbane Street Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 9 1 Burial 2X Cremation 3 Removal from State Department of Important: If any injury or once, Final Journey Crematory 11/19/11 4 Donation 5 Other (Specify) Woodbine, MD 21. Signature of Funeral Service Lices Going Home Cremation Service P.O. Box 784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Clarksville MD 21020 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Lung Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir tran and that initiated events resulting in death) Last Due to (or as a consequence of): physician as s the burial-1 Physician/Medical requires that the death certificate be P.O. Box 68760 the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Division of Vital Records, 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 has performed? certificate 2 🗌 No Yes 2 No 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No ၀ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: After 1X Natural (Month, Day, Year) h Pours after deau...
he Funeral Director; Aft 5 Pending 1 ☐ Yes 2 ☐ No M 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 2 To the F 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) D47964 November 18, 2011

Registrar

DHMH 17 Rev 06-2011

State

18109 Prince Philip Dr. B-100 Olney, MD

20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Deeken, M.D.

31. Date filed (Month, Day, Year) NOV 2 2 2011

Please Type or Print in Black Indelible ink Fraue Al, Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day November 17 Physician/ Vear Mary Allen 7:45 A M 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Randallstown Season's Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours 137-16-9738 Director 1 🗆 M 2 😾 F 91 20 OH 22 02 Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Pikesville Baltimore MD 1 Tes 2 No 10e. Street arg tumber idge 10f. Zip Code 10g. Citizen of What Country? U . S . A . Funeral 23a 21208 8813 Stonebridge Cir. "natural", or items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Newark Board of and Mental Hygiene. Elementary/Secondary (0-12)
12th grade Clerk Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Hill Jackson McOueen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8813 Stoneridge Cir#, Pikesville, Md 21208 19a. Informant's Name/Relationship (Type, Print) Carolyn McCain-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If itel
any injury or ott 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/22/2011 Baltimore, Md On-Site 21. Signature of Funera 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ Pancicatic Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Dusity (or as a consequence of, that initiated events resulting in death) Last Due to (or as a consequence of) the burial Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Second at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Vear P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? s certificate has blirector, page 2 s autopsy performed? Yes 2 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other Specify Other: 잍 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? Natural injury 2 Accident
3 Suicide Investigation 6 Could not be after death Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) ns RajapalneM.D 00057465 11/17/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5203 Baltimore MD 21209. NS Rajapakse, MID. 2835 Smion AV 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Terrill Lee Alther NOVEMBER 20 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner EASTON JAL BOT MEMORIAL HOSPITAL AT EASTON If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** 1**⊠** M 2□ F Months Days Hours Min 219-64-9663 Director 02/29/1956 Maryland Usual Residence of Decedent 10b County 10c. City. Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examinet must be notified at Director 1 No 2 No Caroline Federalsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 118 Bloomingdale Avenue 21632 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or ite Black, White, etc. 1 □Yes 2 📉 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 🛣 No Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Chef Hospitality 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alther Ethel S. Van Pelt Doyal 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If Item 27 is any Injury or other trau once. Marguerite Alther / Sister <u>25245 Calvert Drive, Greensboro, MD 21639</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 11/22/2011 | Hanover, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ISCHEMIC CARDIOMYOPATHY **Physician** /Medical Due to (or as a consequence of): Examiner GASTIED INTESTINAL Sequentially list conditions, if any, leading to minimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MELLITUS DIABETES sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 Tyes 2 MNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☑No 24a Was an page 2 s certificate 1 □Yes 2 ☐No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 TYes 2 TVNo 1 ☐ Inpatient 2 M ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 D'Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) ofur Bolses D0059487 11-21-11 30. Name and add/ess of person who completed cause of death (Item 23a) (Type, Print) Botsis MD, 219 S. Washington Street, Easton, MD 21601 Day, Year) 82. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 11 Physician/ Andrews Constance L. 4:30 A M2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Harford Pel Air 20 N. Atwood Rd. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours 219-40-1311 71 **Director** 1 □ M 2 🔀F 12/05/1940 Maryland Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified Maryland Harford Bel Air 1 XYes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? items 23a Funeral 21014 USA 20 N. Atwood Rd. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. ō þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛮 No Specify: SpecifyWhite "natural", 3 - Widowed 4 X Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Education Ò Custodian 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles O'Neil Margaret Fritz Department of Health and Important: If item 27 is n any injury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 N. Atwood Rd, Bel Air, MD 21014 Randall R. Andrews, Jr. / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State West Chester, Date 1 Burial 2 X Cremation 3 Removal from State 11/22/2011 R.A Ferris & Co. 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania 21. Signature 22. Name and Address of Facility
Tarring—Cargo Funeral Home, P.A.
333 S. Parke St. Aberdeen, MD 21001 mus 23a. Part 1. Enter the dis Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as carriac or respiratory arrest, shock, or heart failure. List only one cause on use h line. Approximate Interval Betweer nset and Death Immediate Cause (Final Physician disease or condition resulting in death) 210 Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) sician and burial-transit Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burfal-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Yes 2X No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 2 No 1 Yes Yes 25. Was case referred to medical B B 26. Place of Death (Check only one) Other: 2 **X** No 1 Yes 2| 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1X Natural 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: T he best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On he basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nusse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ompleted cause of death (Item 23a) (Type, Print) 138 31. Date filed (Month, Day, Year 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#8perFH, G921, 11/22/2011, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month BER 04:25 AM 20 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MORE (In yrs. last birthday) 8. Date of Birth 11/27/55 If Under 24 Hrs. 9. Birthplace (State or Foreign Country) . C. If Under 1 Year Social Security Number Age 5 **Funeral** 1 ■ M 2 □ F 577-78-1258 **Director** Usual Residence of Decedent 28a-f show 10b. County N/A 10a. State 10c. City, Town or Location Baltimore 10d. Inside City Limits must be notified at Director MD 1X Yes 2 No 10f. Zip Code 21225 or 10e. Street and Numbe 10g. Citizen of What Country? 2800 Round Road 23a Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No If Yes, Give 1 977 Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. frican Amer. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important; If item 27 is marked other than " any injury or other traumatic event, the Mea College (1-4 or 5+) U.S. Gov't Elementary/Seconday (0-12) Chef Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Bracey Evelyn Dennis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $2800 \ Round \ Rd$ , Balt., MD 21225Fedora Bracey/Wife 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, Mt. Carmel Cem. 20c. Location - City or Town, State Balt., MD 11/26/11 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hari P. Close F. Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Dusito for as a consequence of sician and burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) ng physician as the burial Physician/Medical Records, P.O. Box 68760 signed by the attending I IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy Yes 2 No 1 Yes 2 No Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospital Other: 2 No မြ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MORE ANOI (Month, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

15,10f&19b Per INF G927 5/29/2012 JH
State of Maryland / Department of Health and Mental Hygiene 20 | | For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Bettua 201T 1900 Sofia Maria November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Prince George's General Hospital Cheverly Social Security Number 086 -42-3292 8. Date of Birth (Month, Day Ye Oct. 29, 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days Min. 19<u>50</u> 1 □ M 2 🖵 F Italy **Director** Usual Residence of Decedent should be filed within 72 hours atter usans and Mental Hygiene. It and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show a file marked other than "matural", or items 23a or 28a-f show a file marked other than "matural", or items 23a or 28a-f show a file marked other than "matural". 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland | Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20715 20755 13505 Ivy Way U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Force Black, White, etc. ğ 1 Never Married 2 Married 2 X No Maryland 21215-0036 1 Yes 2 If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced 4 Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Collegiate Education Administration Education 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eleanor Conte Anthony Coppola 19a. Informant's Name/Relationship (Type, Print) Peter Jerry Bettua / Husband .. Page 1 and 2 sl tment of Health a tant: If item 27 is Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot Date 1 M Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 11-21-2011 4 ☐ Donation 5 ☐ Other (Specify) Assumption Cemetery Syracuse, NY 22 Name and Address of Facility Jr Thomas J. Pirro Jr 3401 Vickery Rd., of Funeral Service Lice Jr. Funeral Home , North Syracuse, NY 13212 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Opent and Death Immediate Cause (Final Physician/ proxa disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner N M Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a conse The law requires that the death certificate be executed physician and s the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last HOS Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? j Day 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death the detached 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕭 Unknown Completed page 2 should peen Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy performed? this certificate 1 Yes 2 No the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred PASS-9 that was 1 Natural 2 Accident injury 5 Pending كردون - ٢ November 3,2011 M 1 Yes 2 No Investigation other 3 Suicide 6 Could not be 28f. Location (Street and Number of Bural Boute Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State street Bowles Medical 29a. Certifier the certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signaty and title of certifie 5 30. Name ay address of person who completed cause of death (Item 23a) (Type, Print) James turas 11 mice Day, Year 2 31. Date filed (Mo 2. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Borowski 19:00 M Frank Navember 20 aoil /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore 8. Date of Birth (Month, Day, Year) July 28,1932 If Under 1 Year Months Days Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Min. 1X M 2 □ F Hours 79 214-26-9846 Director Baltimore, Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examina-10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 □ No Director Maryland Baltimore 10g. Citizen of What Country 10e. Street and Number 10f. Zip-Code United States 21231 733 South Broadway Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐ Yes 2X No Specify: White \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 9 Maintenance Steamship Trade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown Be ပ္ 19a Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12513 Regwood Road, Hydes, Maryland 21082 David Hartman (Friend) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other s Date 20a Method of Disposition 1  $\square$  Burial 2 X Cremation 3  $\square$  Removal from State November 23, Evans Funeral Chapel-Bel 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 2011 21. Signature of Faneral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services-Parkville 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Entertule disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death **Physician** cardiac arrest disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner MFGICE myocardicl Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) that the death certificate be executed that initiated events burial-tran resulting in death) Last Due to (or as a consequence of) physician is the buria Box 68760. Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy atter for in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No P.O. the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 Division of Vital Records, þe 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page performed? 2 No 2 🗌 No certificate Physiclan: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: 1 1 Impatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 ☐ Yes 2 **→ H**o 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Hospital or Attending After 1 Natural 1 Yes 2 No death. 2 Accident Director: A 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 - Homicide after 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only completely 2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number November 20,2011 re5-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 MD 32. Registra

DHMH 17 Rev 1/2001 11595

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Brian Blake P. Month NOV. 18<sup>Day</sup> 20 ั้ำ ำ 4:52 AM Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 2721 Singer Woods Drive Abingdon Harford County Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Hours 219-08-4265 42 Yrs 1968 Maryland Director Usual Residence of Decedent 10b. County and 2 should be filed within 72 hours after death with the Manyland Health and Mental Hygiene. Iem 27 is marked other than "natural", or items 23a or 28a-f sho Ħ 10a. State 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f s notified Maryland Harford County Abingdon 1 ☐ Yes 2 💆 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a o Examiner must be Funeral 2721 Singer Woods Drive 21009 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married 1 Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HVAC Technician **HVAC** 12 traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ರ Vernon J. Butts Theresa Marie Mix 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2721 Singer Woods Drive, Abingdon, Maryland 21009 Theresa Blake (Mother) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel 11/20/2011 Forest Hill, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services-BelAir 3 Newport Drive, Forest Hill, Maryland 21050 TATE Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1, Enter the Approximate Interval Between Onset and Death

Jean Immediate Cause (Final Physician ease liver 015 disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or immediate) Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death signed by the a d be detached f detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy performe 1 🗌 Yes 2 🗌 No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🖳 No 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pendina 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No after death Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral E Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 To the within 2 To the F only one) 29b. Signatur d title of certifier 29c. License number D0070043 anso 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 North Charles Street Baltimore, Maryland 21204 Manson 32. Registrar's Signature State Registrar

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	Physici Medi		1. Decedent's Name (First, Middle, La		BOHL	<u> </u>			2.	Date of Dea Month	ath 2	ay Year <b>1 20</b> 1	3. Time of Death 5 · 30 A M
	Exami	ner	4a. Facility Name (if not institution, given Upper Chesapeake		'enter	4	b. City, Town, or Bel A		n of Death			c. County of Dea Harford	ıth
	Funeral		Social Security Number 6.		ge (In yrs. last bii	M	f Under 1 Year		er 24 Hrs. 8.	Date of Birt	h	9 Bi	rthplace (State or Foreign
	Director		217-07-4406 Usual Residence of Decedent		92	Yrs.			A	Month, Bay	19	19 Mar	yland
	uryland a-f show ied at	ctor	10a. State 10b. County  Maryland Harfo	ord	10c. City, Tow	n or Locati .n <b>qdo</b> n							10d. Inside City Limits
/1	the Ma r or 28	Funeral Director	10e. Street and Number	, L Q	1.01		10f. Zip Code				10g. C	itizen of What C	
7	ith with ms 23e must b	nera	301 Regal Drive	7		las w	21009		0 (0		Uni	ted Sta	
	filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	۾	<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ☐ Married</li><li>3 ☐ Widowed</li><li>4 ☐ Divorced</li></ul>	12. Was Decedent Armed Forces? 1 Yes Yes If Yes, Give Year or Dates.	Ever in U.S. ≸No	If Ye	Decedent of Hes, specify Cuba	an, Mexic	an, Puerto Rica	Yes or No- an, etc.)		14. Race - Ame Black, Whit Specify: W.	
5-0	2 hour "natur edical	Completed	15. Decedent's (Specify only highest g	Education	168	(Give kind	's Usual Occup	durina ma	st of working		16b. l	Kind of Business	Industry
21215-0036	within 7 giene. ner than t, the M	Coll	Elementary/Seconday (0-12)	College (1-4 or	5+)	life. DO N Homem	OT use retired) aker				0	wn Home	
TODO530 D	permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other th any injury or other traumatic event, the Once.	To Be	17. Father's Name (First, Middle, Last) Sylvester Chole		'				her's Name (Fi		Maiden	Surname)	
53( Mar	d 2 shou alth and 27 is m er traums		19a. Informant's Name/Relationship (  Darlene Schmitz	7		_						r Town, State, Zi nd 2100	
O 053C timore, Maryl	Page 1 an nent of He int: If iten ry or oth		20a. Method of Disposition  1  Burial  Cremation 3  4  Donation 5  Other (Spec	Removal from State	20b. Place of Evans Bel	<b>Furier</b>	on (Name of Chap	æl	Nov. 21			ocation - City o	Town, State
70 (Balti	bermit. I Departm mporta Iny inju		21. Signature Ineral Service Lizer	nsee /	, ber	Evan	ame and Address S Funer	al Faci	Mapel 8	& Crem	ati	on Serv	ice-BelAir
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7	Physician/ Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		e. Eumoni	A							Interval Between Onset and Death
	Examiner	П		Due to (or as	a consequence	of):							
7341	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or impury	b. Due to (or as	a consequence	of):							
()-	be execur sician and burial-tra	न्न	that initiated events resulting in death) Last	C. Due to (or as	a consequence	of):							
) (8760	tificate ng phy: s as the	Medi	IF FEMALE:	- d									
DX X	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1  Yes 2  oo 9 Unknown		2  Fetal deat at time of death		ctopic pregnanc ther (specify)	Э				23d. Date of de Month	blivery Day Year
J. P.O.	es that th igned by be detac	by Ph	Part II. Other significant conditions	contributing to death I	but not resulting	in the unde	rlying cause giv	ven in Par	t I.				the cause of death?
7C) ords	v require s been s should	oleted	ADULT ON		BETES	MELL	LITUS		_	1 □ Y 24a. Was a		24b. Were at	Probably 4 Unknown
$V\alpha$	: The lav icate has r, page 2	Com								autop perfor 1  Yes	rmed?	death?	completion of cause of
V∨ Vital	ysiciar is certif directo	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒No	Hospital:	ient 2 🗆 ER/O	utpatient 3	Out	er.	ath (Check oni		ence (	3 ☐ Other (Spec	niful
Jo n	ding Ph h. After th funeral	ate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of inju (Month, Da	ury 28b.	Time of injury	28c. Injury work	y at ?	28d	. Describe ho			
BONII, Wandlet Division of Vital Records, P.O.	I or Attenc after deatl Director:	Medical Certificate:	2 Accident Investigation 3 Suicide 6 Could not determined	be 28e. Place of Inj	ury - At home, fa c. (Specify)			Yes 2 L		Location (Si City or Town			ral Route Number,
	le Hospita 124 hours le Funeral pleted filled	<b>Medical</b>	(Check 2 L. Medical Exan	ysician: To the best of niner: On the basis of e rse Practioner: To the	examination and/	or investigat	ion, in my opinic	on, death o	occurred at the	time, date ar	nd place	e, and due to the	cause(s) and manner stated.
	Voithill To th	V	29b. Signature and title of certifier	late mi		J-, 00000	29c. License	number			29d. Da	ite signed (Mont	h, Day, Year)
6			30. Name and address of person who	completed cause of c	death (Item 23a)	(Type, Print		DCRI	EST CT	BAG	277	TORE M	D 21286
	Sta Registr	te ar	31. Date filed (Month, Day, Year) NOV 2 2 2011		ar's fignature								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G921 11/29/2011 JH
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death BROWN Physician/ Month 10:05 AM LIMTON 20 MOV Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death Examiner 4c. County of Death Columbia Howard Howard County General Hospital 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 154.26.9116 1 M 2 □ F 76 **Director** May 20, 1935 NC Usual Residence of Decedent or 28a-f show notified at 10b. County within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X ☐ No Howard Columbia MD 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ian "natural", or items 23a o Medical Examiner must be Funeral 21045 USA 6160 Waiting Spring 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 🙀 Married þ 1 ☐ Yes 2 X No If Yes, Give X Year or Dates. Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: Black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Ith and Mental Hygiene.
27 is marked other than 'traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Chemical Lab Technician Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Odell Brown Hattie Jones Page 1 and 2 should I ment of Health and Mr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Jacqueline Ellis- Brown - Wife 6160 Waiting Spring, Columbia, MD 21045 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11/22/2011 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation -5 ☐ Other (Specify) Atlantic Crematory  $\frac{1/21/2011}{1}$ Glen Burnie, MD 22. Name and Address of Facility Witzke Funeral Home Inc. Signature of Funeral Ser 411 MOIDS 5555 Twin Knolls Rd Columbia, MD 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death EZ Physician PIRATORY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner SE SHOCK Þ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) PHEUMONIA To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events the burial-trai Due to (or as a consequence of) resulting in death) Last physician Physician/Medical P.O. Box 68760 inding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No Unknown g Unknown signed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, Completed 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform 2 No 1 Yes Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 2 No 욘 1 Inpatient 2 -ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Vatural work? 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the f 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) HYSICIAN 0062704 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ridge Rd. Styles DEJAH MD 3290 N. 32. Registraris Signat State Registrar

DHMH 17 Rev 06-2011.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month 11/ 18/ 2011 02:05 AM <u>Charles Martin Busick</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Upper Chesapeake Medical Center Harford Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Min. 1 XM 2 □ F Hours (Month, Day Year) 01/25/1926 Director 216-20-6112 Marvland Usual Residence of Decedent show ntal Hygiene. ed other than "natural", or items 23a or 28a-f shor event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No MD Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 307D Laurel Woods Drive S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. 1 X Yes 2 No
If Yes, Give
Year or Dates. WW II þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Outside Machinest Steel Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev George W. Busick Amelia Fager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Bradley, Sr. (stepson) <u> 2320 Turner Lane - Bel Air, </u> Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) of Faith Cem. 11/22/2011 Baltimore, Maryland Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. assaki 11750 Belair Road - Kingsville, Marylad 21087 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) M800345344 ue to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): and I-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Box 68760 ast IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has autopsy 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 🗌 Yes 2 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 Natural Certificate: 28d. Describe how injury occurred hin 24 hours after death. the Funeral Director: After or Attending (Month, Day, Year) 5 Pending М 1 Yes 2 No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 5 29b. Signature and title of certifie 29d. Date/signed (Month, Day, Year) 30-Name and address of person who completed cause of death (Item 23a) (Type, Print)

ENUVOIDE ANDE 500 Upper Chisapeake Dr. Bei Air, Mr. 32. Registrary Signat State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 201 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 13 Day Month 2011 11:41a.M D. Brown Priscilla Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2121 Windsor Garden Lane Apt 404 Baltimore 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours Months 80 **Director** 213-26-9493 1 □ M 2**X**□ F 02 06 31 MD Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f shor Examiner must be notified at Director Baltimore 1 X Yes 2 No NA MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a **Funeral** 21207 U.S.A. 2121 Windsor Garden Lane Apt 404 . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedor
Armed Forces?
1 ☐ Yes 2 ▼ No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Harbor City Elementary/Secondary (0-12) College (1-4 or 5+) Cashier Bakery <u>llth grade</u> na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Unknown ၉ Frances Gaines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B712 Windsor Mill Road, Baltimore, Md 21216 Shirley Brown-Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State 11/21/2011 Baltimore, Donation 5 Other (Specify) Mt. Zion 22. Name and Address of Facility March Funeral Home West 4300 Wabash Ave, Baltim of Funeral Service Licen 21. Sign 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final myocardi Physician/ disease or condition Medical resulting in death) Due to ( as a consequence of): **Examiner** oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events physician and s the burial-transit Exami perto Due to (or a la consequence of): resulting in death) Last aftending physician Physician/Medical certificate be Box 68760 as IF FEMALE: signed by the aftending be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery Ectopic pregnancy in the past 12 month 1 Yes 2 No 9 Unknown 5 Other (specify) Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 🗆 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 10 24a. Was an autopsy has certificate Yes 2 1 25. Was case referred to medical the Hospital or Attending Physician: funeral director, 26. Place of Death (Check only one) To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 1 Inpatient 2 ER/Outpatient 3 IDOA after death.

Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aff completely filled in by the fu Accident Investigation 2 ☐ Acciden 3 ☐ Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Li Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Leritfying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) November 14 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD, 21202 anony 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State 22 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11/18/2011 Day LILLIAN MADGE BRADLEY 4:08 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MD MASONIC HOME COCKEYSVILLE BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □XF Days Hours 9/16/1918 WEST VIRGINIA Director 216-28-4040 93 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD BALTIMORE COCKEYSVILLE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 300 INTERNATIONAL CIRCLE 21030 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc 1 Never Married 2 Married Completed by Yes 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes Give Specify: WHITE 3 ♥ Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other traumatic event, the 1 one. REGISTERED NURSE HEALTHCARE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HOMER GUMP MARY WILLY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRED L. BRADLEY, JR.- SON 1341 SWEETBRIAR LANE BEL AIR, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 DOther (Specify) cemetery, crematory or other place) PARKWOOD CEMETERY 11/21/2011 BALTIMORE, MARYLAND Signature of Funeral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME 9705 BELAIR ROAD BALTIMORE, MD 21236 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner in any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of). attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Unknown ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? 2 🗆 No 2 **U**N 1 Yes ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of <u>نة</u> 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending Certifica 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu 29d. Date signed (Month, Day, Year) 20649 wemp 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

John W.

31. Date filed (Month, Day, Year)

Bowie

6701 N. Charles Street

Registrar's Signature

Baltimore,MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1:30 AM E 2011 aulini /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death **Examiner** MD Batimore Battimore arkway Genesis errino If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthdaw 6. Sex **Funeral** 21412900 1 M 2 F Months Days Hours Min. Baltimore, MD 90 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f show the Medical Evantings must be nutified at 1 ☐ Yes 2 ☐ No Baltimou Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 Lossville 8100 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \( \text{Yes} \) 2 \( \text{No} \) 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify. White Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If Item 27 is marked other than Lry or other traumatic event, Ite M Head of Procurement Glen L Martin Co 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Zeiher William J Schafer ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau Pylesville, Maryland 21132 Chuck Hart (Grandson) 4114 Graceton Road 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gardens Nov. 21, 2011 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Storature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home, Inc. 7401 Belair Road Baltimore, Maryland 21236 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** agraio / /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Phyalcian: The law requires that the death certificate be executed sician and burial-trans Due to (or a consequence of) Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 00 3 Probably 4 Unknown 1 Tes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s perform certificate 2 **N**O 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 1 Tes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Sursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation n 24 hours after death. e Funeral Director: Aft bletely filled in by the fur 1 ☐Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of Artifier 29c. License number 30 Name and address of

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland 1 Department and Mental Hygiene 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month William Thomas Barnett November 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 6605 Monroe Avenue Sykesville Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 58 Director 214-52-8894 1 **X** M 2 □ F Sept 30 1953 MD Yrs. Usual Residence of Decede or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director PA Adams Littlestown 1 ☐ Yes 2X No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n ŬSA 17340 1477 Frederick Pike 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 1 X Yes 2 No 1975 If Yes, Give Year or Dates. 0 by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: white "natural", Completed 3 Widowed 4 X Divorced ge 1 and 2 should be filed within 72 hour nt of Health and Mental Hygiene.

If item 27 is marked other than "nature or other traumatic event, the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 College (1-4 or 5+) Elementary/Secondary (0-12) shipping warehouse manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Dorothy Jones William Carroll Barnett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Flural Floute Number, City or Town, State, Zip Code) 6605 Monroe Ave., Sykesville, MD 21784 Mr. David Barnett (brother) 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) County Cremation 11-17-11 Sykesville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Haight Funeral Home & Chapel Parge of aight o P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and De .th shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Dancreatic disease or condition resulting in death) Medical le to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a somequence of). cause. Enter Underlying Cause (Disease or injury Exam -tran that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Racords, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate has death? 2 🗌 No 2 2 No 1 L Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 1 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Spec 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending injury n 24 hours after death.

The Funeral Director: After the funeral is by the funeral process. 1 ☐ Yes 2 ☐ No MA ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 04

State Registrar Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Beazley N. 1:35 P M November 2011 18. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Dundalk Baltimore Genesis eldercare - Heritage Center 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 Months Days Hours Min. July 17, 1920 225-14-6869 91 **Director** Virginia Usual Residence of Decedent or 28a-f show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at **Funeral Director** Maryland Harford Havre De Grace 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 Strawberry Lane Apt 9 21078 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) If item 27 is marked other the or other traumatic event, the 12 years Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jesse Vedder Atwood Dalton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Beazley son 301 Strawberry Lane Apt 9, Havre De Grace, MD.21078 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot November 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place Sparta, Virginia Salem Baptist Cemetery 22, 2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee) 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Her only one cause on each line. ARTERIO-SCLEROTIC CARDIO-VASCULAR Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month Day 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to predical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Funeral Director: After completed filled in by the funer Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident М Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral E Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature oldean (Item 33a) (Type, Stirtly [0 - A TIMO

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State Registrar 32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Bures Marie 18. 2011 9:40 A M November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Franklin Woods Baltimore Nursing Home Rosedale 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Hours Days 214-18-9008 Maryland 89 **Director** 1 🗆 M 2 🗶 F November 25,1921 Usual Residence of Decedent 28a-f shov at 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Maryland Baltimore Dundalk 1 ☐ Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1781 Brookview Road 21222 USA death \ 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 0 1 ☐ Yes 2 X No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2X No Specify. "natural", Specify: White 3 XWidowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 years Secretary Baltimore City Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) August Dobson Nannie Willis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, ge 1 and 2 shat of Health a Bonita Lee Daughter 1781 Brookview Road, Dundalk, Maryland 21222 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November ö 1 XBurial 2 Cremation 3 Removal from State Department of Important: If any injury or Sacred Heart of Jesus Dundalk,Maryland 5 Other (Specify) 23, 2011 4 Donation ture of eral Se Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ LUMONIB disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Dav Year Pregnant at time of death 2 No the 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 1 🗌 Yes 2 🗆 No Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 12 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No filled in by the 1 Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatu dutitle of certifier 29d. Date signed (Month, Day, Year) 30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print) MUNESCA Glev 181 State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ November 14, 2011 7:45 P M Virginia DeAtley Brown Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care Bethesda Montgomery Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Months Days Hours 1 □ M 2 🖾 F Michigan 85 Director 1926 220-28-5052 October Usual Residence of Decedent show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director or 28a-f sl 1 ☐ Yes 2 No Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ms 23a or must be r Funeral United States 5521 Lincoln Street 20817 iral", or items 2 Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married þ 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" Specify: White 3 X Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) e 1 and 2 should be filed within 72 Person and 2 should be filed tygiene.
If item 27 is marked other than "nor other traumatic event, the Median Elementary/Seconday (0-12) College (1-4 or 5+) Medical Artist Art Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ellsworth Francis DeAtley Thelma Winkjer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1013 Curtis Place, Rockville, Maryland 20852 Laura Jeffery / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1:
Department of I
Important: If it
any Injury or of þ Montgomery Crematorium, Inc. 1 Burial 2 X Cremation 3 Removal from State November 19 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. M01619 17557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Weeks Immediate Cause (Final Physician/ disease or condition Respiratory Arrest Medical resulting in death) Due to (or as a consequence of): Examiner years Chronic Obstructive Lung Disease Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Examiner ending physician and use as the burial-transit Cause (Disease or iinjury The law requires that the death certificate be executed Multiple Myeloma with Metasteses that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Coronary Artery Disease Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No φ Month Year Day 1 Yes 2 to 9 Unknown Yes ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed be should be det 23e. Did tobacco use contribute to the cause of death? Completed by Failureto Thrive 1  $\square$  Yes 2  $\square$  No 3  $\maltese$  Probably 4  $\square$  Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Osteoporosis page 2 s has performe certificate 1 Yes 2 No Pneumonia Yes 2 K No Hospital or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 🖾 Nursing Home 5 🗌 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 🗓 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral a 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Gertifying Nurse Practioners to the best of my knowledge, death around at the time date and slace and due to 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D19609 November 14, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10810 Darnestown Road, Suite 202, Gaithersburg Maryland 20878 Raman R. Tuli, M.D. Day, 2 2 2011

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State

Registrar

31. Date filed (Month

NOV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 17, 2011 11:00 AM Burt Roger Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Asbury Methodist Village Gaithersburg Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, . Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 □ F Hours 89 Illinois 358-07-3493 Director August Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at angere. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Gaithersburg Maryland Montgomery 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20877 United States 333 Russell Avenue, #623 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Race - American Indian Armed Forces?
1 X Yes 2 □ No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give WWII Specify: White 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Systems Analyst Defense Contracting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Edith Emigh Paul G. Burt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarissa C. Burt / Daughter 157 Brightwater Drive, Annapolis, Maryland 21407 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) November 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 20, 2011 Bethesda, Maryland Signature of Fun Service bicensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Myrette M01305 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiorespiratory Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) Examine Chronic Obstructive Pulmonary Disease Sequentially list conditions. Examine il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of. or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No ρ Month Day Year Pregnant at time of death Yes the Unknown 9 Unknown ned by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signe should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Assisted Living Hospital Other: 2 X No မြ 4 Nursing Home 5 Residence 6 A Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 1142033 on who completed cause of death (Item 23a) (Type, Print) Martin Portillo, MD 501 N. Frederick Road, Gaithersburg, Maryland 20877 31. Date filed (Month, Day, Year) NOV 2 2 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #29d Per PHY G923 1/04/2011 IH. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Deborah Diane Brown 2011 1:49 P M November 18, Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Timonium If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1/18/1952 Director Maryland 217-58-7611 1 M 2 KF 59 items 23a or 28a-f shoner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Bel Air Maryland Harford 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 946 Creek Park Road 21014 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 🙀 Married by 1 Yes 2 X No If Yes, Give Year or Dates. 1 ☐ Yes 2 🗙 No Specify: Specify: White Completed 3 Widowed 4 Divorced Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. tem 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Education 5+<u>Teacher</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Holland Harriet Dubish 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan Brown / Husband 946 Creek Park Road Bel Air, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp 11/21/2011 | Towson, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.

Immediate Cause (Final disease or condition and death)

ANCLEAT C CANCEX. Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to lor as a consequence of: Cause (Disease or injury that initiated events resulting in death) Last for use as the burial-trai Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 XNo
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of the Hospital or Attending Physician: The law eral Director: After this certificate has filled in by the funeral director, page 2 autopsy performed death? 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation within 24 hours after deat

To the Funeral Director:
completely filled in by the 3 🔲 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gertifying Nurse Fractitioner: To the best of my knowledge. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 11/18/2011 of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Name (First, Middle, Last) 2 Date of Death Time of Death Physician/ .0 NOWEMORR Medical Facility Name (if not institution, give street and number 4c. County of Death Examiner 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) 213-11-5238 26 Director MD 1 □ M 2 🗓 K Yrs 06/21/1985 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director items 23a or 28a-f s her must be notified NJ OCEAN LAKEWOOD 1 Yes 2 No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 125 EAST 8TH STREET 08701 USA death v 12. Was Decedent Ever in U.S.
Armed Forces?

1 ☐ Yes 2 🕅 No
If Yes, Give
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Black, White, etc. "natural", or by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 X No Specify. WHITE Specify 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed, than , Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Hygiene. the SPECIAL EDUCATION TEACHER EDUCATION Department of Health and Mental Hygie Important: If item 27 Is marked other any injury or other traumatic event, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic event</u>, <u>traumatic eve</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ROCHEL **JEFFREY** SINGER CAPLAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl tment of Health a AVROHOM BARENBAUM / HUSBAND 125 EAST 8TH STREET LAKEWOOD, NJ 08701 20a Method of Disposition 20b. Place of Disposition (Name of cernetery, crematory or other place) 20c. Location - City or Town, State 1 Donation 5 Out 1 CHOFETZ CHAIM CEM. 11/20/2011 Donation 5 Other (Specify) ROSEDALE, MD Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Ma 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Lemic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Due to or as a conse wence of Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical P.O. Box 68760 the als IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death the 9 Linknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ■No 3 □ Probably 4 □ Unknown Records, 1 🗌 Yes been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy perforr death? 1 Yes 2 No Yes 25. Was case referred to medical examiner? Division of Vital director Be 26. Place of Death (Check only one) Hospital Other: 1 Tes 2 မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After work?
1 Yes 2 No 1 Natural 5 Pending injury safter death, I Director: Af d in by the fu 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide filled in by determined City or Town, State 24 hours a Funeral I Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Childers, M.D. Ryan

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20 Day 1:45 AM JOY **BROOKS** NOV. 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death SEASONS HOSPICE AT NORTHWEST HOSP. BALTIMORE RANDALLSTOWN If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) PA Social Security Number 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) 7/2/1927 Director 168-20-4572 1 🗆 M 2XXF 84 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified MD N/A BALTIMORE 1XX/es 2 □ No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 6503 PARK HEIGHTS AVENUE 21215 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes XX No
If Yes, Give Black, White, etc. "natural", or 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify. WHITE 3 Widowed 4 XX Vivorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) FASHION COORDINATOR **FASHION** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ POLIKOFF MARTIN ELSIE SERFER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBBIE LOGUE / DAUGHTER 3800 GLEN AVENUE: BALTIMORE, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) ROOSEVELT MEM.PARK 11/21/2011 TREVOSE, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service I 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD: BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. rval Between MUNNU Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to for sels consequence on Exami Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 Other: မ ER/Outpatient 3 DOA 1 Inpatient 2 I 4 Nursing Home 5 Residence 27. Manner of Death Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatur ompleted cause of death (Item 29a) (Type, Print 177 2835 J. MWK WHUT 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** FRANCES BRESSLER 16:45 PM NO JEMBER 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Baltimore City | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. Dec 29, 1966 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Maryland 218-62-2715 44 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amplying or other traumatic event, Item Model Examiner must be notified at once. 1 ☐ Yes 2 No Director Md. Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 21222 8041 Del Haven Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔏 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2**X** No If Yes, Give Year or Dates: Specify: ģ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)  $\overset{\text{Elementary/Secondary (0-12)}}{12\text{th}}$ College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Henry L. Siarkowski Rita L. Burdyck မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Paul K. Bressler / Husband 8041 Del Haven Road <u>Dundalk</u>, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition November 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Rosary Cem. 22,2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Kaczorowski Funeral Home, P.A. 21. Signature of Funeral Service Licensee M00933 Rolus Dundalk Avenue Baltimore. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 7 days PREUMONIA disease or condition resulting in death) /Medical (or as a consequence of): **Examiner** Cirrhosus Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Witar/Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Month Day Year 5 Other (specify) signed by the a 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tes 3 Probably 4 Unknown After this certificate has been significate has been significantly funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 🖾 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural nours after death. neral Director: Aft y filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) and manner stated.

State Registrar

DHMH 17 Rev 1/2001

AARON

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHUE

MAN

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

21224

NOVEMBER

4940 Eastern Avenue Baltimore, Md.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8: 00 A OL rn Medical Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** antertand Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Min. **Director** 1 M 2 F 28a-f show 10c. City, Town or Location 10b. County Oa. State 10d. Inside City Limits notified at Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? must be Funeral 23a items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Medical Examiner Black, White, etc. ö 1 Never Married 2 Married þ 1 Yes 2 fill If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: "natural" 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) of Health and Mental Hygiene item 27 is marked other the other traumatic event, the Be Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ sh.burn (Son) 19a. Informant's Name/Rel ionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Marss C+ Kandallstown, MD Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🗹 Cremation 3 🗆 Removal from State any injury or 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat Funeral Service Licensee eval 23a. Part 1/Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Small Cell Caren one ancer disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or se a consequence of,: it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No been signed by the atte should be detached for Month Day Year 1 ☐ Yes 2.5 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has k completely filled in by the funeral director, page 2 s If or Attending Physician: The law after death.

Director: After this certificate has autopsy perform 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) Assignment 2 No Hospital မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural N Division 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier ho completed cause of death (Item 23a) (Type, Print) Blud 21236 pbell State Registrar

110

8

November

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Earl James Chinault 1 Month 2011 Year  $\mathbf{P}^{\,\mathsf{M}}$ 18 6:05 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 18 Bosley Lane Reisterstown Baltimore If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral 8. Date of Birth Birthplace (State or Foreign Country) Days Hours (Month, Day, Year) 07-29-1924 **Director** 219-12-7662 1 🕱 M 2 □ F 87 Maryland Usual Residence of Decedent 28a-f show 10b. County the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 😾 No Maryland Baltimore Reisterstown 10e. Street and Number 10g. Citizen of What Country? items 23a 18 Bosley Lane 21136 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 0 1 Never Married 2 Married þ 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify. Specify: marked other than "natural" Completed 3 XWidowed 4 ☐ Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. Clerk U.S. Postal Service 12th grade 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) William Chinault Catherine McNamara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Chinault - SON 18 Bosley Lane, Reisterstown, MD 21136 item 20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery 11–23–2011 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Baltimore Maryland 5 Other (Specify) 22. Name and Address of Facility MacNabb Funeral Home P.A. 21. Signature of Funeral Service Liq 301 Frederick Road, Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Onset and Death Immediate Cause (Final Physician/ VEARS disease or condition Medical resulting in death) Examiner CARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death 9 Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 No 1 Yes or Attending Physician: Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? 2 No Other: 1 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work ours after death.

leral Director: Aft
filled in by the fur 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the I within 2 29b. Signature and title of certifier TTENDING 30. Name and address of pers n who completed ause of death (Item 23a) (Type, Print) 720 CHAIDEN Choice LA ACHICAN 31. Date filed (Month, Day, Year) NOV 2 2 2011 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Donald Thomas Carmine 11 2011 9-25 วก Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Care Towson Baltimore If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Unde 8. Date of Birth **Funeral** Hours Min (Month Day Year) **Director** 212–26–7064 Usual Residence of Decedent 1 ★M 2 ☐ F 82 Yrs May 30, 1929 Maryland show or 28a-f shov notified at 10b. County with the Maryland 10a, State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 712 Eastshire Drive 21228 United States items 2 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. Race - American Indian. 11. Marital Status "natural", or iten edical Examiner i med Forces? Black, White, etc 1 X Yes 2 If Yes, Give Year or Dates 1 Never Married 2 X Married by 2 No Maryland 21215-0036 within 72 hours after Specify: WHITE 1 ☐ Yes 2 X No Specify: 3 - Widowed 4 - Divorced Completed Silver ...
It and Mental Hygiene.
27 is marked other than "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Plumber PLumbing 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Thomas Jefferson Carmine Elva Elizabeth Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. 712 Eastshire Drive, Catonsville, Maryland 21228 Ida Rae Carmine - WIFE Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Metro Crematory INC 111-26-2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society Of Maryland INC Signature of Frederick ROad, Baltimore, Maryland 21228 23a. Part 1. Enter the disease a complications that caused shock, or heart failure. List only one cause on each line. he death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between inset and Death Immediate Cause (Final Physician UNG CANCER Due to (or as a consequence of): disease or condition Medical resulting in death) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Physician/Medical death certificate be Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death the: 9 Unknown 9 🗌 Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of reuse of death? 24a. Was an has performed 2 No 1 Ves Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) NOV 2 2 2011 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 Per PHY G921 11/22/2011 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nov. 19, Dorothy Reberta Greer Cain 2011 2:45 A. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1403 Bowles Terrace Forest Hill Harford County ocial Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Date of Day, Year)
(Month, Day, Year)
1 12,1945 **Funeral** 1 □ M 2 🛛 F 218-46-4103 Months Days Hours 66 Director April Maryland Usual Residence of Decedent f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford County Edgewood 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 612 Dogwood Avenue 21040 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed 3 - Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Special Projects Citizens Care Center 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Hugh L. Poe Lillian M. Coe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie Steele (Niece) 1403 Bowles Terrace, Forest Hill, MD 21050 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Mem Gdns 11/23/2011 Bel Air, Maryland Evans Funeral Chapel & Cremation Services -BelAir 3 Newport Drive, Forest Hill, Maryland 21050 21. Signature of Funeral Service Licensee cur en 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Certificate: To Be Completed by Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Yes Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No Yes 🕰 1 Tes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Niece's Home examiner?
1 Yes No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Sesidence XX Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation 3 
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical TECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) dress of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

Registrar

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ısan Christian		State of Maryland / Department of Healt  1- For State Certificate of Death Registrar			20 l	1 3716			
Physicia Adical Exami	an/	1. Decedent's Name (First, Middle,Last) Susan Gayle Christian		2. Date of Death Month November	Day Year	3. Time of Death 1636 hrs			
			own, or Location of Death		4c. County of Deat	h			
Funeral Director			r 1 Year If Under 24Hrs Days Hours Min	_	(MM/DD/YYYY) 9. Bi Forei				
ow any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Maryland Baltimore Parkville				10d. Inside City Limits 1 Yes 2 X No			
with the Maryland ns 23a or 28a-f show be notified at once.	Director	10e. Street and Number 10f. Zip	Code 234		g. Citizen of What Co. United Sta	intry?			
72 hours after death with the Maryland n "matural", or items 23a or 28a-f she sal Examiner must be notified at once	— L	1 Never Married 2 Married Armed Forces? If Yes, specify 1 Yes 2 X No	nt of Hispanic Origin? ( S Cuban, Mexican, Puerto		White, etc.	rican Indian, Black,			
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	à	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual 0	No specify: Decupation (Give kind of ting life, DO NOT use ret		Specify: Whi				
5-0036 iled within 7: Hygiene. I other than	Completed	12 2 Systems Ar.		e (First, Middle, Ma	Conseco				
2121 uld be fi Mental J marked	Be	Evia J. Christian  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address	Olive (Street and Number or	M. Pinne Rural Route Numb		e, Zip Code)			
		20a. Method of Disposition 20b. Place of Disposition (Nam	**	Date	ille, Mary 20c. Location - City o				
Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumat		4 Donation 5 Other Specify:	Air 20	ember 19, )11	Forest Hi	ll, Marylan			
Physician	g y	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of failure. List only one clause on each line.	Address of Facility Funeral Chapel Harford Road I f dying, such as cardiac o	arkville, or respiratory arres	on Services— Maryland 212 st, shock, or heart	Approximate Interval Between Onset and			
Examiner		Immediate Cause (Final disease or condition resulting in death)  all cohol Intexication Complete to (or as a consequence of):	icated by I	rowning		Death			
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Universitying Cause (Disease or injury that initiated							
so, e be executed ysician and burial - transit	Ex	events resulting in death) Last  Due to (or as a consequence of):  d.  AMENDED 23a,27,28a-f,per me	2.0923 1-18-	-12 sm					
OX 6876 Path certifical attending ph For use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 ✓ Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Special Special 3 Ectopic pregna		23d. Date of deliver Month	ry Day Year				
P.O. Brees that the designed by the	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.		acco use contribute to	the cause of death?			
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been s led in by the funeral director, page 2 should !	Completed			24a. Was ar autops perform 1 ✓ Yes 2	y prior to ned? death?	utopsy findings available completion of cause of			
Vital Rehysician: The this certificate I director, page	o Be C	25. Was case referred to medical examiner?  1  Yes 2  No  Hospital: 1  Inpatient 2  ER/Outpatient 3  Do	6.Place of Death (Check DA Other Mursin		tesidence 6 🗸 Othe	er: Scene			
ion of tending Ph eath. tor: After t	ation: T		Bc. Injury at Work?	subject intoxica					
Divis pital or A ours after of eral Direc	Certification	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Residence 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7224 Old Harford Rd. Baltimore, Md.							
To the Hos within 24 h completely	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	opinion, death occurred		nd place, and due to t	he cause(s)			
	Σ	29b. Signature and title of certifier 29c.	O.C.M.E.		November 17, 2				
		30. Name and address of person who completed cause of death (Item 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore	e Street, Baltimore	, MD 21223					
S <sup>.</sup> Regis	tate trar	31. Date filed Worth Day Year 011  3. Registrar's Signaline							

11-08619					
Timothy Craig					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

imothy Craig		State of Marylar		ent of	Health and	Menta	l Hyg	iene	2.0	1	1 3717
Physician/		1- For State Registrar Certificate of Death  1. Decedent's Name (First, Middle,Last)						Reg. No. 2 3. Time of Death			
Medical Examiner		Tillbury d. ordig						Month Day Year 1227 hrs			1227 hrs
		4a. Facility Name (if not institution, give street and num Johns Hopkins Hospital	ber)	41	o. City, Town, or l Baltimore	ocation of D	eath		4c. County of N/A	Death	
Funeral Director			Age (In yrs. last birt	thday)	If Under 1 Year Months Days	If Under 2	Min			Foreiar	nplace (State or
Director	ŀ	219-60-7325 1X M 2 F Usual Residence of Decedent	58	Yrs.				May 31,	1953	Cou	ntry) Maryland
Maryland 28a-f show any 1 at once.	ţō	10a. State 10b. County  Maryland N/A	10c. City, Town Baltin								10d. Inside City Limits  1 Yes 2 X No
with the Maryland ns 23a or 28a-f sho be notified at once,	Director	10e. Street and Number 2205 Pelham Avenue			10f. Zip Code 21213			100	g. Citizen of Wha	t Count	try?
ms 23a		11. Marital Status 12. Was Deced	lent Ever in U.S.		Decedent of Hisps, specify Cuban,						an Indian, Black,
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sh ral Examiner must be notified at once	by Funeral	1 Never Married 2 Married 1 Yes 3 Widowed 4 Divorced If Yes, Give Year or Dates:  15 Decedent's Education (Specify only highest grade	2 X No	1 🗌 🗅	Yes 2 No	specify:			Specify:	Wh	ite
5-0036 led within 72 hours Hygiene. other than "natur	Completed	Elementary/Secondary (0-12) College (1-4	or 5+)		st of working life.				N/		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	æ	17. Father's Name (First, Middle, Last) Samuel A. Craig, Jr. 19a. Informant's Name/Relationship (Type, Print)	194	h Mailing	1 Address (Street	Esther	Hele	n Henneg		State	Zin Codo)
MD 21 d 2 should lth and Me n 27 is ma numatic ev	욘	Mary R. Craig/ Sister	130		7 Murdock				yland 21		Zip code)
itea an		20a. Method of Disposition  1 XX Burial 2 Cremation 3 Removal from		of Dispositi ory or othe	ion (Name of cem er place)	etery,	Da	ate	20c. Location - C	ity or T	own, State
Baltimore, pemit. Pages la Department of He Important: Hite	1	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Sacred		of Jesus		11/1	9/11	Dundalk	Mary	land
Derm Depa Inpu	1	Vita A. Helle		15305	me and Address lard J. Ruc Harford I	Road Ba	altim	ore MD	21214		
Physician /Medical		23a. Part I. Enter the disease, or complications that cau failure. List only one cause on each line.		ot enter the	mode of dying, s	uch as card	ac or res	spiratory arres	it, shock, or hear	9	Approximate Interval Between Onset and Death
Examiner	1	Immediate Cause (Final disease or condition resulting in death)  a.Atherosc  Due to (or as a condition)	elerotic Consequence of):	ardio	ovascula	r Dise	ease			$\dashv$	Death
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a co	onsequence of):							-	
4	kamir	(Disease or injury that initiated events resulting in death) Last C.  Due to (or as a content of the content of	onsequence of):	, ,		-				- 1	
executed an and al - transit	dical Examiner	d.  MI UNPENDED AMENDED 2	3a,27,28a	-f.pe	er me.g9	23 1-2	20-12	2 sm		-	
7 <b>60,</b> cate be e	₩ed	IF FEMALE: 23c. If yes, ou	tcome of pregnancy	-,,	782				23d. Date of de	elivery	
The part of the pa						Month	Da	ay Year			
P.O. Es that the c		Part II. Other significant conditions contributing to d	eath but not resulting	g in the un	derlying cause gi	ven in Part I.				_	ne cause of death?
The part of the pa						ere auto	opsy findings available impletion of cause of				
tal Reco	S S							perform 1 ✓ Yes 2		ath? Yes	2 No
Vital Rec bysician: The l this certificate I	o Be	25. Was case referred to medical examiner?  1 Ves 2 No Hospital: 1 Inc	eatient 2 ER/Ou	utpatient		of Death (Ch			esidence 6	Other:	Scene
ion of \text{teodiog Pby} eath. to: After the funeral	⊢†	27. Manner of Death 28a. Date of (Month, D		Time of Inj	ijury 28c. Injury at Work? 28d. Describe how injury occurred						
Sior Atteod r death ector: by the i	lăt E	2 Accident Investigation 28e Place	-16-11 fd of Injury - At home, fa		an	es 2 🗶 No		known	eet and Number	or Rur	al Route Number, City
Division  To the Hospital or Attendit within 24 hours after death.  To the Funeral Director: /	Certification:	Suicide Could not be	residence			nomig, oto.		or Town, Sta	te) <b>2205</b> P	e1h	am Ave.
the Hos in 24 ho ibe Fun pletely	- 1	29a. Certifier 1 Certifying Physician: To the best of cone one 2 Medical Examiner: On the basis of									
To T with To com	Medical	and manner state 29b. Signature and title of certifier			29c. License	number	OMF		29d. Date signed		
	I	Theodore M. King	JR. m	· D.	O.C.N		. 71 11 1		November 1	7, 20 <sup>-</sup>	11
0		Name and address of person who completed cause Theodore M. King, Jr., MD. Assistan	of death (Ifem 23a) t Medical Exami	iner 9	00 W. Baltime	ore Street	t, Baltii	more, MD	21223		
Sta Registi	3.50	31. Date filed (Month, Day, Year)  NOV 2 9 2011	strar's Signature	. 1							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 17 Month 3:46 **Physician** 201 llanoRa 0 10 Vembe /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 KF Months Days Hours Min. 67 Director 216-42-5834 Jun 01, 1944 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County 28a-f show Examiner must be notified at 1 Yes 2 ☐ No Director MD Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? death with items 23a or 4808 Lorelly Ave. Funeral 21206 Apt. 1D <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. be filed within 72 hours after on tal Hygiene. Set other than "natural", or iter 1 ☐ Yes If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: Specify. ð 3 Widowed 4 Divorced Year or Dates: Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Department of Social Services Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental is marked o Pages 1 and 2 should b ment of Health and Ments ant: If item 27 Is marked ည Elmer Wedworth Berry Louise Janette Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catriece Hollins /Daughter 4748 Elison Ave. Baltimore, MD 21206 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If its any injury or o once, cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Nov 19 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2011 Beltsv

22. Name and Address of Facility
Cremation and Funeral Alternatives 21. Signature of Funeral Service License MO1585 Kelecca Achemon 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Securificity list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner use as the burial-transit Mesentino De 1101 resulting in death) Last Due to (or as a consequence of): a ending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 ment 1 Yes 2 No ō Month Year 5 Other (specify) detached P.O. the Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Division of Vital Records, pe 4 Unknown 1 Tes 2 No 3 Probably Completed plnoqs peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed 2 No After this certificate 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA မ 27. Mary er of Death filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 V Natural 1 Tes 2 No death. 2 Accident Director: 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined 4 - Homicide or A after 24 hours Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only completely 2 🗌 Medical Examper: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. To the Within 2 29b. Signature and the certifier 29c. License number 29d. Date signed (Month, Day, Year) 5-001 30. Name and address of person who dompleted cause of death (Item 23a) (Type, Print) Mac 4940 Eastern Avenue, Baltimore, MD, 21224

DHMH 17 Rev 1/2001 11595

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 18 State of Manyland 1 Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CHISULM 14 5:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Edgewood tartord If Under 1 Year If Under 24 Hrs. cial Security Number 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign -38-1095 1 M 2 F 72 Months Hours Min. Country) Director Yrs MA 28a-f shov aţ 10a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 No 0 10f. Zip Code 10g. Citizen of What Country? **23**a Funeral 21040 tom items Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Armed Forces?,
1 Yes 2 No o, 1 Never Married 2 Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. "natural". 3 X Widowed 4 ☐ Divorced If Yes. Give Specify: Black Year or Dates other traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Hide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 roster De Lugenia Westley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health a Important: If item 27 is any injury or other tra Benson-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Men. F Middle River HOLLY ignature of Funeral Service Licer 22. Name and Address of Facility March FH1101 E. North t 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cock. or heart failure. List only one cause on each the. Approximate Interval Between s ock, or heart failure. List only one cause on each Immodiate Cause (Final Onset and Death Physician, HRONIC dise se or condition re ulting in death) ENAL Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to manufactoristic cause. Enter Underlying Cause (Disease or iinjury Examiner (of as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed as the burial-transit HYPERTEN and that initiated events resulting in death) Last Due to (or as a consequence of physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown for Pregnant at time of death Month Day n signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has page 2 autopsy performed? 1 Yes 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Hospital: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 IDOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Ka mond 1 2ren 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YORK 32. Registrar's Signature NOV 22 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2611 8:22pm M CHESTER THOMASINE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Montgomery Silver Spring If Under 1 Year If Under 24 Hrs. 5. Social Security Numbe 7. Age (In yrs. last birthday 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 030nth, Day 8'ear) 1924 1 🗆 M 2 🔀 F 286-20-3795 87 OHTO Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director Prince Georges Fort Washington 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 529 with Redcoat Place 20744 USA death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. þ 1 Never Married 2 Married filed within 72 hours after Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black "natural", 3 

Widowed 4 □ Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event. The Man Elementary/Seconday (0-12) College (1-4 or 5+) Bookbinder Government 12+h Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, John Thomas Smith Evans Addie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ronald Thomas 529 Redcoat Place Fort Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Arlington National Centery 11/17/2011 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Close F.H. 5126 Helaur Ro Baltimore, ND21206 21. Signature of Funeral Service Licensee Bianchi 814 Upsnur St NW Wash, DC 20011 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician **ASCVD** disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): bunial-transit Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 as the t IF FEMALE: yes, outcome of pregnancy nse 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) ed by the a g 🗌 Unknown P.O. cate has been signed by page 2 should be detact Part II. Othe<mark>r significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autonsy this certificate 1 Yes 2 No Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 24 hours after death.

Funeral Director: After (Month, Day, Year) 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident within 24 hours after death

To the Funeral Director: A

completed filled in by the f 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) the Hospital Medical X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) puz

State Registrar CARONYN SHORN

Date filed (Mopth, Day, Year)

100 2 2 2011

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 18<sup>Da</sup>2011 22 35 Helen Catherine Coles Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Towson 4c. County of Death
Baltimore **Examiner** Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth cial Security Number 7. Age (In vrs. last birthday) **Funeral** 220 36 2199 June 19 1941 Director 1 🗆 M 2 🗙 F Baltimore, Maryland 70 Usual Residence of Dece show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 28a-f Harford Maryland Fallston 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 9 must be Funeral 23a 21047 113 Fallston Meadow Court USA items death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐**X**No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Black, White, etc. 6 þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Specify. "natural", Completed 3 Widowed 4X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Legal Secretary Whiteford, Taylor & Preston the Be event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic ever 2 Margaret Catherine Hurlock Charles Raynor 19a. Informant's Name/Relationship (Type, Print)
Steven P Moore 19b. Mailing Address (Street and Number or Rural Boute Number, City, or Town, State, Zip Code, 113 Fallston Meadow Court Fallston, Maryland 21047 nt of Health a :: If item 27 is other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 💢 Cremation 3 🗀 Removal from State Metro Crematory Inc November 21 2011 ō Department or Important: If any injury or Baltimore, Maryland 4 Donation 5 Other (Specify) ure of Funeral Service Licenses Cassann Foreral Hore Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the case, or complications that caused shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate interval Between Immediate Cause (Final Onset and Death Ph\_si\_ian ADVANCED LEERS disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to or as a consquence of burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregrant in the past 12 months? 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 mg Month Day Year Pregnant at time of death 1 Yes 2 Leg 9 Unknown be detached the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an 24b. Were autopsy findings available page 2 prior to completion of death? has autopsy performed 2 No this certificate 1 Yes funeral director, To Be 25. Was case referred to predical 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 1 Yes 2 🗔 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manus of Death Certificate: 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After t completely filled in by the funer. injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 06-2011

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

lonth, Day, Year,

NOV 2 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 20(1 Edna M. Caulfield 1:47 AM OV Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALT WASHINGTON 4 LEN BURNIE med CTR Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Country) Maryland 214 22 2765 1 M 2 X F Months Hours 0971011926 85 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is an arted of ther than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Glen Burnie Maryland Anne Arundel 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S. 21060 1605 Kimber Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò 1 Never Married 2 K Married Yes 2 K No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Wire Processor Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Orem Sappington Thelma Harmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard Caulfield / Husband 1605 Kimber Road Glen Burnie, Maryland 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 👿 Burial 2 🗆 Cremation 3 🗆 Removal from State 11/23/2011 4 Donation 5 Other (Specify) Baltimore, Maryland Cedar Hill Cemetery 21. Signatu of Fureral Service Lice 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EREBROVASCULAR ACCUPIENT Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Other (specify) Pregnant at time of death 9 Unknown 1 ☐ Yes ∠ ₩ 9 ☐ Unknown been signed by the should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performe death? certificate 2 No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Director; 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Funeral Dire 1

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation is my policies, death occurred. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cerumer 29c. License number 29d. Date signed (Month, Day, Year) Edmin 00059190 NICY 21 2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 HOSPITAL BR ECEN BARLY 20061 State Registrar

		For State	Type or Print in Black State of Maryland / D	epartme		Mental Hy	giene 20		
		Registrar     Decedent's Name (First, Middle, Last)		Certifica	le Ul Dealli	2. Date of De		3. Time of Death	
Physic		Frances Eliza				Novembe	er 7,201	Year 1235 P	
/Med Exami		4a. Facility Name (If not institution, give	street and number)	4b. Cit	, Town, or Location of Death		4c. County	1433 F	
LAGIIII	1161	Bradford Oaks Nur	sing & Rehab	C1	inton		Prince	e George's	
Funeral Director		5. Social Security Number 6. Se	7. Age (In yrs. last birti	hday) If Und Months	or 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Bir (Month, Da Nov 28	rth 2y, Year) 1910	9. Birthplace (State or Foreign Country) Culpeper, VA	
Maryland f show	tor	10a. State 10b. County  Maryland Prince G	eorge's Temple	or Location				10d. Inside City Limits  XXYes 2 □ No	
with the la or 28e	Directo	10e. Street and Number 3515 Riviera Stre			ip Code 20748		10g. Citizen of United		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.  Department of Health and Mental Hyglene.  Important: If item 27 is marked other then "naturel", or iteme 23a or 28e-1 show eny Injury or other traumatic event, the Medical Examinat must be notified at a ponce.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Dec If Yes, sp	edent of Hispanic Origin? (Secify Cuban, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. Rac Bla Specif	ce - American Indian, ck, White, etc.	
vithin 72 hounder.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation 16a. le completed) 16a. College (1-4or 5+)	(Give kind of v life. DO NOT		king		usiness/Industry	
lied y		Sixth N 17. Father's Name (First, Middle, Last)	one I	lomemak	er 18. Mother's Nan	ne (First Middle	None Maiden Surnar	ne)	
ntal hed of	Be						, maison coma	,	
d Me	10	John Wiggins  19a, Informant's Name/Relationship (T)	(ne Print) 19h	Mailing Addre	Anna ss (Street and Number or Ru		ner City or Town	State. Zip Code)	
d2 s d2 s th an t7 is u		Frazier T. Colema		•	viera Street,				
Heal Heal		20a. Method of Disposition			ame of other place em Nove			- City or Town, State	
ages nat of refire		1 🗷 Burial 2 □ Cremation 3 🕮			Church 15,2		Lionum	,Virginia	
artme	. X	4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens						uneral Home Inc	
Deprise Personal Pers	ļ.	Donald R Gray	MKKY		Good Hope Rd				
Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	incations that caused the deam. Do necause on each line.  a. Atherosclerotic  Due to (or as a consequence of	cardic	ode of dying, such as cardiac	or respiratory a		Approximate Interval Between Onset and Death 4 years	
Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of						
e be executed sicien end burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	of):					
The law requires that the death certificate be executed the has been signed by the ettending physicien end page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	3 □Ectopic 5 □ Other				ate of delivery onth Day Year	
w requires that it been signed by should be deta	ğ	Part II, butter significant contained to the butter to the sum of the discontinuous contained to the butter to the sum of							
The law rec	Completed								
stan: ortifice ctor, j	BeC	25. Was case referred to medical examiner?				ath (Check only			
Physician: rthis certificaral director,	10	1 ☐ Yes 2 <b>X</b> No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	tpatient 3			sidence 6 □Ot		
*Attending Physician: The lav er death. rector: After this certificate has by the tuneral director, page 2:		27. Manner of Death 1 □Natural 5 □ Pending 2 □ Accident investigation		Injury 28b. Time of 29c. Injury at Work?  Injury M 1 Tyes			28d. Describe how injury occurred		
To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the tuner	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, fac	ory, office		. (Street and Number or Rural Route Number, rown, State)		
To the Hospil within 24 hour To the Funer completely fill.	Medical	29a. Certifier	vsician: To the best of my knowledge iner: On the basis of examination an and manner stated.	e, death occurr d/or investigati	ed at the time, date and place on, in my opinion, death occ	e, and due to the urred at the time	e cause(s) and n e, date and place	nanner as stated. , and due to the cause(s)	
To the To the Comp	M	29b. Signature and title of certifier	$\neg$		9c. License number 045365		29d. Date signed (Month, Day, Year)  November 9,2011		

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Sidarous MD 11701 Livingston Road, #101, Ft Washington Maryland 20744

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 32 PM Physician/ Donald Lee Cutlip NOVEMBEL Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL Number 6. Sex Baltimore singu of Baltimore Social Security Number Birthplace (State or Foreign Country) **Funeral Director** 1 M 2 D F 213-44-9608 65 Nov. 18, 1945 Washington 10b. County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at **Funeral Director** Maryland Harford Whiteford 1 Yes 2 XNo or 28a-f 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? or items 23a 4063 Prospect Road 21160 USA Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify. 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Material Handler Cabinet Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Henry Basil Cutlip Geraldine (nmn) Rudd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vera Ellen Cutlip / Wife 4063 Prospect Road, Whiteford, MD 21160 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Keurial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Air Memorial Gdn 11-21-11 Bel Air, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death **Physician** disease or condition Medical resulting in death) Examiner Sequentially list conditions Physician/Medical Examiner if any leading to in-modal cause. Enter Underlying Cause (Disease or injury that initiated events cdionyapa resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atticl Fibrillation, Coronary steats, post 1 Yes 2 No 3 Probably 4 Nhknown mpocerdial Infarction, Dichetes Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Oirector, After this certificate has I completely filled in by the funeral director, page 2 : autopsy Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 은 1 Thpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Accident iniury work? 1 Yes 2 No 5 Pending Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) RE5-00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belvedele Ave Baltimore, AD 21215 wes? 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 9 Registrar

DHMH 17 Rev 06-2011

Corald

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 12159 Cooper, Jr. 1105 George W. /Medical 4a. Facility Name (If not institution) give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HARFOR KIVERSADE DELCAMP If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Hours South Carolina **Director** 247-48-8412 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show Injury or other traumatic event, the Medical Examinar must be notified at Director 1 XYes 2 No MD Harford Aberdeen 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò USA 21001 208 Schmechel St. 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? or items 14. Race - American Indian, Black, White, etc. 1X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ∐Yes 2 XXNo Specify. Specify: White ģ 3 Divorced 4 Divorced "natural" Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) US Government 11 Civil Service is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental F Oveda Turney ပ္ George W. Cooper, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 Schmechel St, Aberdeen, MD 21001 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or and Shirley Ann Cooper / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 11/23/2011 Burial 2 Cremation 3 Removal from State Aberdeen 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gardens 22. Name and Address of Facility Tarring Cargo Funeral Home, P.A. 21. Signature of Funeral Service Licensee Aberdeen, Maryland 21001 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): burialattending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy

☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.O. the detached 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ≥ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 □Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes ♀□No cate has page 2 s certificate Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) this Certification: To 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: A mpletely filled in by the fu death. 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 29227 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATRICIA DWYSU W GISW. N Cels W. Marphail RL Beldir NO 21014

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) NOV 2 2 2011

32. Registrar's Signature

1. Decedent's Name (First, Middle, Last)  Physician/  Month  April (Valte S	eg. No. 20   37179 h 3. Time of Death Day Year 5'.   S A M
Physician/ Mary (vates	Day Year
Examiner  4a. Facility Name (if not institution, give street and number)  Northwest Hospital  4b. City, Town, or Location of Death  Windsor Mill:	4c. County of Death  Baltimore Co.
Funeral  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  Months  Days Hours Min. (Month, Days, Month)	9. Birthplace (State or Foreign
Isual Residence of Decedent 61 Yrs. 01/14/	1950 WashingtonDC
10c. City, Town or Location	10d. Inside City Limits
MD Baltimore Co. Pasadena  10f. Zip Code	1 ☐ Yes 2 ☐ No  Og. Citizen of What Country?
MD Baltimore Co. Pasadena  10e. Street and Number  4049 Brummel Rd  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  Armed Forces?  10c. City, Town or Location  Pasadena  10f. Zip Code  21122  11. Marital Status  12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	U.S.A.
11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
The specific control of the sp	Specify: Black
So to the standard of the stan	16b. Kind of Business/Industry
Elementary/Secondary (0-12) 6th Grade 17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, N	Medical Facility
77. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Name)	-
John Thomas Coates  John Thomas Coates  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number,	
19a. Informant's Name/Relationship (Type, Print)	City or Town, State, Zip Code) 21122
20a. Method of Disposition  20b. Place of Disposition (Name of Date	20c. Location - City or Town, State
1 Burial 2 <b>X</b> Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) on-site Crematory11/18/11	Baltimore, MD
Gloria Coates (daughter) 7870 Shirley Murphy Ct. #  Gloria Coates (daughter) 7870 Shirley Murphy Ct. #  20a. Method of Disposition (Name of cemetery, crematory or other place)  1   Burial 2   **Scremation 3   Removal from State   Crematory 11/18/11    21. Signature of Funeral Service Licensee   Canada   Cana	neral Home PA Ltimore, MD 21217
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause on each line.	
Physician/ Immediate Cause (Final disease or condition resulting in death)  Medical Final Cause (Final disease or condition resulting in death)	Onset and Death
Medical resulting in death)  Due to (or as a consequence of):	
Sequentially list conditions, if any leading to firm rediction cause. Enter Underlying	
Cause (Disease or injury that initiated events c	
p p p p p p p p p p p p p p p p p p p	
VOR ON THE PROPERTY OF THE PRO	
23b. Was decedent pregnant in the past 12 months?	23d. Date of delivery  Month Day Year
1   Yes 2   No 9   Unknown 9   Unknown	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tob	acco use contribute to the cause of death?
	s 2 No 3 Probably 4 Unknown
Becords,  The law requires  Completed  Completed  1   Ye  24a. Was ar adutops perform autops perform 1   Yes 2	prior to completion of cause of death?
The state of Death (Check only one)  1  Yes 2  25. Was case referred to medical examiner?  1  Yes 2  26. Place of Death (Check only one)	No 1 Yes 2 No
The state of the s	nce 6 Sother (specify)
28d. Describe ho	v injury occurred
The proof of the part of the p	eet and Number or Rural Route Number,
Space   Spac	<u> </u>
So the result of the cau of the c	place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier 29b. Signature and title of certifier 22b. License number 22c. License number 22b.	d. Date signed (Month, Day, Year)
296. License number  NSRAPUMM 7  29c. License number  00057 4 b 5	11/13/11
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  A 5 Rajapakse, Min. 7835 Smith AV 5 203 Baltimore Mi	21209
State Registrar  31. Date filed (Month, Day, Year)  NOV 2 2 2011  32. Registrar's Si nature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ / Month 1400 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Himore (meneral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗹 F Country) Months Hours Min. Director or 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Ses 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral items 23a 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 2 No ō þ 1 Never Married 2 Married 21215-0036 within 72 hours after Yes If Yes, Give Year or Dates. 1 ☐ Yes 2 ☑No Specify: "natural", 3 Widowed 4 Divorced Completed lac 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life, DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ be injury or other traumatic a Page 1 and 2 should thent of Health and Me Sister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S-Important: If item 27 any injury or other tra 110 ree Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Signa cility uneval Home, P. A 23a. Part f. Enter he disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Kenal End Stage disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last evere attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director After this certificate has I performed 1 ☐ Yes 2 ☐ No 2 - No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 4 No မြ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? Accident
Suicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) Amandep 16/11 168 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 0 egistrar's Signature State 2011 NOV Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3, PM DAWSON IRNA PATRIC Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c County of Death **Examiner** (J 000 Samaritan H Dspital Baltmore MD 8. Date of Birth (Month, Day, Year) Sept. 22, 1936 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Hours 219-32-5130 Director 1 M 2 DE 75 MD Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Baltimore 1 Yes 2 No Essex the ! 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? r items 23a or ner must be n Funeral 617 MAce Avenue 21221 USA Page 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Medical Examiner Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Nidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene.
27 is marked other than "
r traumatic event, the Med Baltimore County Elementary/Secondary (0-12) College (1-4 or 5+) Food Service Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles Knoerlein Hedwig Klapka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 730 Middlesex Road Balto. MD 21221 Department of Health Important: If item 27 any injury or other tr Dorthea Markwood /daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 11/21/11 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 MAce Ave. Balto. Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Oncet and Death Immediate Cause (Final Physician/ Severe multiple Organ SE 0313 Wills disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner androgenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner STEM attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be datached for use as the burn P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal dea Pregnant at time of death 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ renal Division of Vital Records. 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an Typerlipidfuc performed 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospital Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) ည 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical YCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 1171011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUNDE Raven Bullevand

DHMH 17 Rev 06-2011

State Registrar TUI

31. Date filed (Month, Day, Year) NOV 2 2 2011

32. Registrar's Signature

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: within 24 hours after death To the Funeral Director: A

Baltimore, Maryland 21215-0036

resulting in death) Last	d							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23d. Date of delivery  Month Day Year							
*	ntributing to death but not resulting in the underl E JOINT DISEASE	ying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unkn					
			24a. Was an autopsy performed 1  Yes 2 2					
25. Was case referred to medical examiner?		26. Place of Death (Check only one)						
1 Yes 2X No	Hospital: 1 ☐ Inpatient 2 ☐XER/Outpatient 3	☐ DOA Other: 4 ☐ Nursing H	ome 5 🗌 Residence	6 Other (Specify)				
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation		28c. Injury at work?	28d. Describe how in					
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	and Number or Rural Route Number, ate)						
(Check 2 ☐ Medical Examir only one) 3 ☐ Certifying Nurs	ician: To the best of my knowledge, death occur ner: On the basis of examination and/or investigation e Practitioner: To the best of my knowledge, deat	on, in my opinion, death occurred a	at the time, date and pla	ace, and due to the cause(s) and manner stated.				
29b. Signature and title of certaier	1/ 1	29c. License number	29d.	Date signed (Month, Day, Year)				
Jev Ha	1/21/11	D15452		11/21/11				

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

TIMOTHY BESSENT M.D. 7601 OSLER DRIVE TOWSON, MD 21204

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 5:32 AM Physician/ Month OPGI NOVEMBER 13 2011 MARY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Sinai Hospital N/A Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 217-24-8493 **Director** 1 □ M 2 👿 F 81 Yrs April 4, 1930 Maryland 28a-f shov 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits with the Maryland other traumatic event, the Medical Examiner must be notified at **Funeral Director** MD N/A Baltimore 1 ¥ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 21201 USA 124 W. Franklin Street 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 IV No
If Yes, Give
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ō þ 1 Never Married 2 Married filed within 72 hours after 21215-0036 1 ☐ Yes 2 M No Specify: Specify: Black "natural", Completed 3 Wildowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 12th GRade Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WEldon Whitaker Bessie Bailev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tratonce. Lynda Wilson - Daughter 3607 Landbeck Road Lochern, Maryland 21207 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11/28/2011 Carrison Forest Vet. Cem. Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 20 5240 Reisterstown Road Baltimore, MD. 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition Due to (or as a consequence of): Medical resulting in death) **Examiner** Hyperzawcist Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by DISENCE STACE MONAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown 24b. Were autopsy findings available prior to completion of cause of death? HARO THURSIDICM 24a. Was an this certificate has autopsy performed?
1 Yes 2 No 1 Yes 2 No To the Hospital or Attending respective within 24 hours after death.

To the Funeral Director: After this certifical the Funeral Director of the funeral director, in the funeral director, in the funeral director, in the f 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Mursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 P Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1'É Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and hitle of certifier 29c. License number te BONUSE 11/14/16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. working. A BAN work 700 with HINGTON Bry 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ つ ö Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Linthicum Tate Hospice House 5. Social Security Number If Under 1 Year If Under 8, Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Min Days Hours Dec. 26°,17947 Marvland 63 Director 216-44-5912 Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 No Pasadena Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ms 23a or must be n Funeral 21122 782 Powhatan Beach Road items 2 Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Yes Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than " Elementary/Seconday (0-12) College (1-4 or 5+) Architect-Self-Employed Architecture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည Helen Romaine Mummert Leonard G. DiPaula, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau once. Julie Barth 782 Powhatan Beach Road, Pasadena, Maryland 21122 20b. Place of Disposition (Name of 20c. Location - City or Town, State Ardent Cremation, Inc. 11-16-11 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee muhael 6009 Harford Road, Baltimore, Maryland 21214 Margalle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical ttending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Yes 2 No been signed by the should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 🗌 No 3 Probably 41 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform page 2 death?
1 Yes 2 No director. 25. Was case referred to medical 26. Place of Death (Check only one) 2 V No 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 2 🗆 No Investigation
6 
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) mpleted cause of death Item 23a) (Type, Print) GENEVIEU State Registrar

Box 68760

P.0.

Division of Vital Records.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Barbara Elaine Dunivant Physician/ November 19, 2011 10:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Colora **Examiner** 4c. County of Death Love Run Road 101 Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 218-46-2266 Months 10/11/1948 1 - M 2XXF Director 63 SC Cecil 28a-f show items 23a or 28a-f sho her must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Colora 1 Yes 2 X No 10e. Street and Number Run Road 10f. Zip Code 21917 10q. Citizen of What Country? Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 9 þ 1 Never Married 2 X Married 2 X No Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Impoctant: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)

Mary Hutto ည Carl Jamison 19a. Informant's Name/Relationship (Type, Print) . 195 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1331 Dr. Jack Road, Conowingo, MD 21918 Christina R. Dunivant / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crematory 11/21/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Marshall 22. Name and Address of Facility
Maryland Cremation Ser
PO box 1413, Baltimore 21. Signature of Funeral Service Licensee Orota 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir that initiated events resulting in death) Last Due to (or as a consequence of): physician at s the burial-1 Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year Yes ed by the a detached f 9 Unknown P.O. signed by i Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Tes 2 No 3 Probably 4 Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? and No Hospital Other: 1 Yes မြ 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death,

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending М 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 铽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November Day **Physician** 3:20PM ohn 201 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □XM 2 □ F 65 218-44-4337 May 18, Ohio 1946 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show at 1 ☐ Yes 2 ☐**X**No Sparrows Point notified Director Baltimore Maryland 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 0 death with must be 9107 North Point Road 21219 items 23a USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status should be filed within 72 hours after on Mental Hygiene. marked other than "natural", or ite Examiner or i 1 Never Married 2 Married Specify: White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xo Specify ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8 years Supervisor Construction permit. Pages 1 and 2 should be filee.
Department of Health and Mental Hygis any Injury or other " 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Larry Davis Katherine Say Nicolette 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Viola Davis wife 9107 North Point Road, Sparrows Point, MD. 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 1 XBurial 2 Cremation 3 Removal from State Gardens of Faith Rosedale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 23, 2011 21. Signature of Funeral Service License 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. nly one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** therosclerotic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence on attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical certificate has been signed by the attending physionirector, page 2 should be detached for use as the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2X No 2 🗌 No 1 Yes 1 🗌 Yes Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA ည Hospital or Attending Phys 24 hours after death. Funeral Director: After this filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 Tes 2 🗌 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (N 2. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November Physician/ Helen Μ. Dodson 2011 10:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Nursing Home Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours 579-24-8478 1 🗆 M 2 🔀 F 86 Director February 7, 1925 Virginia Vrs Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location with the Maryland notified at Director 1 🗆 Yes 2 ื No Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? ms 23a or must be r Funeral 3609 Janet Road 20906 United States Page 1 and 2 should be filed within 72 hours after death \u00e4ment of Health and Mental Hygiene.
ant if it fem 27 is marked other than "natural", or items
uny or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Armed Forces?
1 Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify If Yes, Give Year or Dates 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ James Henry Maley Margaret Lester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna D. Hanlon /Daughter 3609 Janet Road, Silver Spring, Maryland 20906 Department of Health Important: If item 27 any injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 1, X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery 2012 Arlington, Virginia 21. Signature of Funeral Service Lice Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland letter M01305 20850-2805 Part 1. After the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 23a. Part 1. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hypertensive Heart Disease Medical resulting in death) Due to (or as a consequence of): Examiner Diabetes Mellitus Sequentially list conditions, Examine Duy to (or as a nonsequence of) If any, leading to in redicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Advanced Dementia and the burial-trar Due to (or as a consequence of) ding physician Physician/Medical Sigmoid Volvulus Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Pregnant at time of death Other (specify) ed by the a 9 Unknown 9 Unknown signed by: Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 L Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Xivursing Home 5 A Residence 6 A Other (Specify) 1 🗆 Yes 2 🔀 No Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Investigation Accident after death Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled within 24 hours a To the Funeral Completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) DSUNV D0047330 November 15, 2011 Swomas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50 West Edmonston Drive, Rockville, Maryland 20852 Thomas Joseph, MD

DHMH 17 Rev 06-2011

Registrar

State

31. Date filed (Month, Day, Year)

NOV 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death L. Decedent's Name (First, Middle, Last) Month Physician/ 4:30 PM Horace November Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner S. Monastery Ave. N/A Baltimore 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5 Special Security Number 214-26-2379 **Funeral** (Month, Day, Year) 1 XM 2 🗆 F Director 04/05/1930 81 Maryland 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" permitted or other trainment. 10c. City, Town or Location 10a. State 10b. County Director 1 XYes 2 No N/A Baltimore MD 10g. Citizen of What Country? 10e. Street and Number Funeral 23 S. Monastery Ave. 21229 U.S.A. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Black, White, etc Armed Forces 1 Never Married 2 Married Yes 2 No þ 1 Yes 2 No Specify Specify: Black If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Bethlehem (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Steel Laborer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Indiana Coston William Diggs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2134 Braddish Ave., Baltimore, MD 21216 Robert Diggs(brother) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State on-site Crematory 11/28/11 Baltimore, MD 4 Donation 5 Other (Specify) <sup>2</sup>Joseph H. Fulton Ave., 21. Signature of Funeral Service Licenses Funeral Home PA Baltimore, MD 2 uam MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy has performed 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medica 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 🗌 Yes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred filled in by the funeral After injury 1 🗹 Natural 5 Pending Investigation Accident after death 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MSRyapaneNI.D

State Registrar 2835 Smin

32. Registrar's Signature

N 5203

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N-S. Rajapakse/Min

2011

(Month, Day, Year)

31. Date filed (Month,

MO 21209.

Baltmore

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State Registrar					d / Depa		t of H	lealth a		Mental Hy		ne 2 C	)	37	189
Physicia Medic		1. Decedent's Nam  Dorothy	Į.	F	berl	У		T				2. Date of Domestin		Day 2011	Year	3. Time of 2:00	Death  P  M
Examin	er	4a. Facility Name (if not institution, give street and number) 4308 Folly Quarter Road						4b. City, Town, or Location of Death Ellicott City						4c. County <b>Howar</b>			
Funeral Director	er.	5. Social Security N 054-16-38 Usual Residence	6. Sex	-	(In yrs. Ia 91	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D Feb 8,	ay, Year,	ar) Cou			r Foreign	
Maryland 8a-f show	irector	10a. State	10b. County Honoli	ulu			y, Town or Loc <b>lulu</b>	cation								10d. Inside Cit	
h with the	Funeral Director	10e. Street and Number 175 Kaulana Way						10f. Zip 968					10g. (	Citizen of V	What Cou	ntry?	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates.					U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or North If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2 ▼ No Specify:					ecify Yes or No Rican, etc.)	w	14. Race - American Indian, Black, White, etc. Specify: White			
/ithin 72 hou iene. <b>r than "nat</b> <b>the Medica</b>	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)						ia. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					16b. Kind of Business/			ndustry	
d be filed w Mental Hyg arked othe atic event,	To Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)															
nd 2 shoul lealth and I m 27 is m		19a. Informant's Name/Relationship (Type, Print)  Etta Ellen Stanley/daughter  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  4308 Folly Quarter Rd. Ellicott City, MD 21											<sup>Code)</sup> 21042				
t. Page 1 a tment of H tant: If ite ijury or otl		4 Donation	Cremation 5 Other (S		om State	C	lace of Dispo emetery, cren al Jou	natory or of	her place Crema	atory	11/	· ·	Woo	Location -	e, M	D	
Physician/ Medical Examiner	Examiner	23a. Part 1. Enter the shock, or head the shock, or	the disease, or rt failure. List o Final on on ditions, amediate rlying injury s	complications the nally one cause on a. Gas  a. Pare b. Due	each line. <b>troir</b> to (or as a	ntest consequ mal N consequ	251 Be n. Do not ente cinal I lence of): Nocturi ence of):	everly or the mode Bleed	y L.	Heck	rott cardiac c		. C.	P.O larks	.Box	784  Approximate Interval Betwo Onset and D	veen
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Medical	in the past 12 r 1 ☐ Yes 2X	3b. Was decedent pregnant in the past 12 months?  1  Yes 2 No  23c. If yes, outcome of pregnancy  1 Live Birth 2 Fetal death 3 Ectopic pregnancy  1 Other (specify) Month Date of delivery											ear			
quires that the en signed by t	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Chronic Atrial Fibrillation  1  Yes 2 No 3 P															
si <b>cian:</b> The law rec certificate has be lirector, page 2 sho	Completed											1 🗆 Yes	psy ormed?	i d		psy findings av mpletion of ca 2  No	
nysiciar nis certif I directo	To Be	25. Was case referred examiner?  1  Yes 2 X		Hospital:	Inpatier	nt 2 🗆 I	ER/Outpatien	t 3 $\square$ DC	Other	ce of Deat		only one) me 5 $\square$ Resi	dence	Othe	Dai (Specify	ighter'	s
Attending PI er death. ector; After th by the funera	Certificate:	27. Manner of Death  1X Natural 2 Accident 3 Suicide 4 Homicide	5 Pending Investig 6 Could r determi	ation ot be 28e. Pla		Year) y - At hor	28b. Time of injury	М		at	No	28d. Describe	how inju	nd Numbe	ed		er,
e Hospital or 124 hours aft Funeral Dir letely filled in	Medical Co	(Check 2	Medical Ex	Physician: To the	pasis of exa	ny knowle	edge, death o	igation, in m	y opinion	n, death occ	curred at	the time, date :	ause(s)	and mann	to the car	use(s) and man	ner stated.
To the within to the comp	2	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Date Signature)  29d. Novimmin 18										Day, Year)					
12		30. Name and addre	ckson,	M.D. 34	use of dea	ath (Item	23a) (Type, P	rint) urt #2				20832					
Stat		31. Date filed (Month	h, Day, Year)	32.	Registrar	's Signatu	ure	•									

DHMH 17 Rev 06-2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ricky Edwards State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day November 13, 2011 1315 hrs Ricky Edwards Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore Washington Medical Center** Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 1 **X X** M Country) 2 F Nov 4-1964 246-31-2486 47 Usual Residence of Decedent E S 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 XX Yes 2 No rages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene.

other traumatic—
other traumatic— Bennettsville Marlboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ۵ USA 3073 Stanton's Rd. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 **XX** No Yes 1 Yes 2XX No specify: 3 Widowed 4 XX Divorced If Yes, Give Year SpecifiAmerican Indian ě 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Itimore, MD 21215-0036 Medical Truck Driver 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Viola Freeman Purcell Edwards 19a. Informant's Name/Relationship (Type, Print) ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3073 Stanton's Rd., Bennettsville, SC 29512 Viola Freeman Edwards Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 XX Burial 2 Cremation 3XX Removal from State Nov 19, 2011 Hamlet, NC Edwards Family Cemetery Donation 5 Other Specify Signature of Funeral Service 22. Name and Address of Facility
Fink Funeral Home, P.A. Gregory Pink 426 Crain Hwy S., Glen Burnie, MD 21061 M01148 d I. Entire the eale, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician se on each line reen Onset and /Medical Death a Fluoxetine and Nortriptyline Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical X UNPENDED  $\square$  AMENDED 23a, 27, 28a-f, per me, g921 11-29-11 sm the attending physician and for use as the burial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 1 Live birth 3 Ectopic pregnancy Month Day Year past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≨</u> 1 Yes 2 No 3 Probably 4 Unknown Completed has been page 2 should 24b. Were autopsy findings available autopsy prior to completion of cause of performed? ✓ Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: this 1 🗸 Yes 26a. Date of Injury (Month, Day Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 1 Yes 2 X No hours after death Pending unknown To the Funeral Director: fd 11-13-11 the fd 12:33 pm Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 767 204th St. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide Filled determined (Specify) Residence Pasadena, Md Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 14, 2011 Mound 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month) gistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Karen Marie Fix 6:46 P M November 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Towson Gilchrist Center Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** Min (Month, Day, Year) 050-42-8410 Director 1 🗆 M 2 💢 F 63 Sept 12,1948 New York Usual Residence of Decedent at 10b. County 10c. City, Town or Location Director must be notified 28a-f 1 XYes 2 ☐ No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? Funeral 23a 5402 Willowmere Way 21212 USA "natural", or items death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 Yes 2 Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 2X No 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4X Divorced Year or Dates. ntal Hygiene. sed other than "natura sevent, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) P**l**anner Corporate Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည of Health and Menta fitem 27 is marked rother traumatic e Josephine Petracosta Phillip Bifulco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jared Fix, Son 1815 N. Orchard Street Unit 8 Chicago, IL 60614 Department of Health Important: If item 27 any injury or other tronge. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Metro Crematory Inc. 11/22/11 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License Thomas Gregor <sup>22</sup> Name and Address of Facility
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause ors that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, see neach line. Interval Between Onset and Death Immediate Cause (Final Physician/ MEPISMI Courcer worths disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Dav Pregnant at time of death been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔊 nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy To the Hospital or Attending Physician: The 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 No ၉ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No М Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Sign of person who completed cause of death (Item 23a) (Type, Print) eracles ST TONSON MD Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Harvey Edward Flynn, Jr. 10°1 AM 23 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Franklin Square Hospital Kosedale If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 03, 1944 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 213-42-3207 Director 1 XM 2 □ F 67 Baltimore, Maryland Usual Residence of Decedent show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sl notified Maryland Baltimore Parkville 1 Yes XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 21234 United States 17 Hapsburg Court items? 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter Black, White, etc. by 1 Never Married 2 X Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify. 3 Divorced 4 Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Drywaller <u>Fidelity Engineering</u> other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental မ is marked Harvey Edward Flynn, Sr. Lillian Salisbury other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Pauline Flynn (Spouse) 17 Hapsburg Court, Parkville, Maryland 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery crematory or other place.
Evans Funeral Chapel-Bel
Air 1 Burial 2 XCremation 3 Removal from State November 22, 4 ☐ Donation 5 ☐ Other (Specify) 2011 Forest Hill, Maryland 21. Signature of Fyneral Service Licensee

22. Name and Address of Facility

Evans Funeral Chapel & Cremation
880 Harford Road Parkville, M

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus on each line. Evans Funeral Chapel & Cremation Services 8800 Harford Road Parkville, Maryland 21 Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and the burial-tra Due to (or as a consequence of) resulting in death) Last Physician/Medical requires that the death certificate be P.O. Box 68760 use as IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy detached for in the past 12 months? Year Month Day Pregnant at time of death Yes 2 No Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ standing Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed7 death? 1 Yes 2 No of Vital To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 🛮 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manyner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 🗹 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division Accident Suicide after death. Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated title of certifie completed cause of death (Item 23a) (Type, Print) 900 2 State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Frederick William Forkel, Jr. 9:00 November Medical 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Year If Under 24 Hrs. 8. Date of Birth (Month, Day, ) June 28, Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 9. Birthplace (State or Foreign 1 ፟M 2 □ F New York 117-10-3019 94 Director 1917 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 717 Maiden Choice Lane #211 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White Specify: 3 X Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Religion Minister Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick William Forkel, Sr. D. Lillian Granberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh Department of Heatth a Important: If item 27 is Susan Hamrick-Daughter 8103 Tide Rock Square; Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Crest Lawn Mem.Garden 11/23/2011 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify Marriottsville, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Signature of Funeral Service 1630 Edmondson Avenue: Catonsville 23a. Part 1. Enter the disease or complications that caused the death) Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line HYPOXIA Immediate Cause (Final Onset and Death Priysician/ disease or condition resulting in death) Medical Due th (or as a consequence of): Examiner HEART EAI CURE 362571VE Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, Cause (Disease or iinjury STEALOS ORTIC that initiated events resulting in death) Last attending physician and for use as the burial-trai Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death 5 Other (specify) Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate 1 ☐ Yes 2 ☐ No Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) in 24 hours after deaun. he Funeral Director, Affer this or noleted filled in by the funeral dire Certificate: To 2 **1** No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 261825 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REYNALDO 900 CATON AVENUE BALTIMORE MD 7/229 LCACERILMS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 11:04 a M Nov. <u>Lois Naomi Ford</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Timonium Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min (Month, Day, Year) **Director** 1 M 2 XF 225-14-8399 88 Yrs. July 25, 1923 Virginia Usual Residence of Decede Show or 28a-f shown notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🙀 No Maryland Glen Burnie Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a o Funeral with 1 21061 United States 214 Ridgeley Road death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married 2 X No 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify White Completed 3 X Widowed 4 Divorced er than "natur, 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Transportation 12 years and Mental Hygie is marked other Sustomer Service-Railroad Be 17. Father's Name (First, Middle, Last) Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) မ David Connor Eva Plott traumatic and 2 should the Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Gloria Kemp (Daughter) 214 Ridgeley Road Glen Burnie, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Date NOVEMBER emetery, crematory or other place) 5 Other (Specify) ardens of Faith Cemetery 11/18/11 Baltimore, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
Dundalk, Maryland 21222 21. Sign ure a 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ END STAGE PARKINSON'S DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transl Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Day Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes Yes 2 X N Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 TO Other (Specify) HOSPICE 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 2300 DULANEY VALLEY RD. TRACIE MORGAN CRNP TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Florence FELDMAN Physician/ 20, 2011 3:15 A November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring <u>Leisure World Blvd, #29-20</u> 9. Birthplace (State or Foreign Permisylvania If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Days Feb. 3, 41931 1 M 2 XF Months Director 80 205-24-1394 28a-f shov 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Director Silver Spring Montgomery 1 Yes 2 XNo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20906 3507 S. Leisure World Blvd., #29-20 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. Specify: White 3 ₩ Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rebecca Shulman မ Benjamin Watzman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 7:3-24de) 12110 Little Creek Dr., Potomac, MD 20854 Brian J. Feldman, Son 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of B'nai Israel Cemetery 11/22/11 Pittsburgh, PA 4 Donation 5 er (Specify) 21. Si catora f Fune al Serv Porchitisky Hettrew Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part 1. Early the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 1.5 Years Physiciani Metastatic Breast Cancer disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events the burial-transi and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Day Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) 1 Yes 2 L 9 Unknown be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of certificate has autopsy performed? Yes 2 No page death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 🗓 No 1 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 A Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: Ai completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year) D 0061083 November 21, 2011 ann au 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9707 Medical Center Dr., Ste. 300, Rockville, MD 20850 M.D. Thambi State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month  $\mathbf{P}^\mathsf{M}$ Foster-Horton November 3:17 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Village Montgomery 19027 Coltfield Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 K Min (Month, Day, Year) 09/05/1952 Georgia 556-90-7949 Director 59 Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 No Montgomery Village MD Montgomery 10f. Zip Code 23a or 10e. Street and Number 10a. Citizen of What Country? Funeral "natural", or items 23a 20886 U.S.A. 19027 Coltfield Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married ☐ Yes 2 🗓 No δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Black Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than alth and Mental Hygiene. 27 is marked other than r traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Government Grants Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health, and Mental Important: If item 27 is marked of any injury or other traumatic eve once. ပ Emma Doris Smith Louis Foster Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stacy Harris / Daughter 19027 Coltfield Court, Montgomery Village, MD20886 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Anatomy Gifts Registry 11/22/2011 Hanover, Maryland 4 X Donation 5 Other (Specify) 21. Signature Funeral Service Li Ansee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease shock, or heart failure. L e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph i i n disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami The law requires that the death certificate be executed the burial-transit that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death detached 9 Unknown 9 Unknown s been signed by i should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an has autonsy page 2 death? 2 No certificate 1 Yes Yes 2 Division of Vital Hospital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 2 No Hospital: Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 🗌 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work?
1 Yes 2 No 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu M Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifier LXCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D040970 2211 30. Name and address of person who ed cause of death (Item 23a) (Type, Print) HO 20877 authersburg 50 Fredrick Novile Registrar's Signature State 2 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 75, 2011 12:51 AM John S. Fitzhugh, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Worcester Atlantic General Hospital Berlin If Under 1 Year Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** Hours 1**XX**M 2 □ F 1/7/1936 ear) 215-32-5428 75 Director MD Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shov ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director FLNorth Fort Myers 1 Yes 2XXNo Lee 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 33903 IISA 1321 Thompson Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces' þ 1 Never Married 2XX Married Maryland 21215-0036 1XXYes 2 No If Yes, Give Specify: White 1 ☐ Yes 2XX No Specify: 3 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Telephone 12 Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leon Fitzhugh Dora Mattingly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra North Fort Myers, FL 33903 Mrs. Virginia Fitzhugh / Wife 1321 Thompson Street Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 11/18/2011 Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation / Funeral Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 161 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ hrehi'c disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No
9 Unknown Hospital or Attending Physician; The law requires that the death Day Month Year Pregnant at time of death P.O. signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Xes 2 No 3 Probably 4 Unknown of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? To the Funeral Director: After this certificate completed filled in by the funeral director, page 1 Yes 2 X No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 Nation 2 ER/Outpatient 3 DOA Certificate: 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DOOG 4/20

Registrar DHMH 17 Rev 7/2009

State

AD

Aget 9733 Health way Drive Bellin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Zeeshan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Funke 4:24P M Dorothy 11 16 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Timonium Stella Maris If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Days Hours Min. (Month, Day, Year) 1 □ M 2 ★ F 213-34-1482 73 Director Maryland 04/11/1938 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Westminster 1 Yes 2 No MD Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 30 Locust Street 21157 U.S.A. Apt 606 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal any injury or other traumatic event, the Medical Exal If Yes, Give Specify: White 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Manager Retail 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dorothy Carlyle Carrol1 Berry Mary Thomas 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Tracy Marie Rostkowski / 1114 Johnsville Road Sykesville, MD 21784 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 11/23/2011 Glen Burnie, MD 4 Donation 5 Other (Specify) Atlantic Crematory 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Joil Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ENEBLOVASCU Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, each glock introduction cause. Enter Underlying Cause (Disease or injury Due to (or ex-a nonsequence of Exami burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ for 1 in the past 12 months?

1 Yes 2 X No
9 Unknown Day Year Pregnant at time of death been signed by the seriould be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the reversal Director, After this certificate has been six for one pleased by the funeral director, page 2 should I Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of De th 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending Investigation M Suicide 6 Could not be 3 ☐ Sulciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and 29c. License number who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 19, 2011 **JEROME FADER** 10:34 A<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death GILCHRIST HOSPICE CARE BALTIMORE TOWSON If Under 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) 212-34-5095 **Director** 1 🗶 M 2 🗆 F 77 MD 04/11/1934 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2900 STONE CLIFF DRIVE, UNIT 403 21209 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify. WHITE Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ AUTOMOTIVE EXECUTIVE AUTOMOTIVE RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 MAURICE FADER ANNE SIMON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2900 STONE CLIFF DRIVE, UNIT 403 BALTIMORE, MD 21209 RHEDA FADER / WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Removal from State cemetery, crematory or other place, 5 Other (Specify) BALTIMORE HEBREW CEM. 11/21/2011 REISTERSTOWN, MD 21. Sign 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE. 23a. Part 1. Enter the dispass or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ MOTASTATIC ANGIOSARCOM MOUTHS disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-trar and Due to (or as a consequence of): physician Physician/Medical certificate be Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death Month Day Yea! the P.0. ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPORTONSION 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed HYPOTHYROLDISM 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has page 2 certificate 2 1 No 1 Yes 25. Was case referred to medical or Attending Physician: funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Dato ျ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?

1 Yes 2 No Accident 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier ortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner To the best of my knowledge at the time, date and plane, and the to 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) LETH CHARLES STREET PAUTINIS

DHMH 17 Rev 06-2011

State Registrar 11-08600 Kevin T. Frain

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 37200 Certificate of Death 1- For State Reg. No Registrar 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Month 2045 hrs November 15, 2011 Medical Examiner Kevin Thomas Frain c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Washington Hagerstown 208 South Prospect Street If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** oreign Country New York Months Days August 16, 1955 56 Director 158-50-3342 1XX M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County E S 10a. State 1 Yes 2 xxNo Hagerstown Maryland Washington or 28a-f show permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21740 U.S.A. 208 South Prospect Street 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 xx Married 1XX Yes White 1 Yes, Give Yea 1976-1980 Specify: 1 Yes 2 XX No specify: 3 Widowed 4 Divorced ੬ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Building Maintenance College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Owner 12 Company 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bridget M. Redmond Harry E. Frain, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 557 Henry Street Hellertown, PA 18055 Diana Frain wife 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 XXCremation 3 Removal from State Glen Burnie, Maryland Nov 20, 2011 Atlantic Crematory 4 Donation 5 Other Specify 22. Name and Address of Facility McCully Polyniak Funeral Home, P.A. 21. Signature of Funeral Service Licenses 30 East Fort Avenue, Baltimore, MD 21230 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line Death /Medical a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine eause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED UNPENDED attending physician or use as the burial 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Month Dav 3b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown for Unknown After this certificate has been signed by the funeral director, page 2 should be detached fi 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown 虿 Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed death? ✔ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25 Was case referred to medical Z Ital å Other Nursing Home 5 Residence 6 Other: Scene examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes ဥ 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27 Manner of Death Certification 1 Yes 2 No 1 V Natural To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: 5 Pending filled in by the 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be determined 4 \_\_\_ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 16, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol Allan, MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Mostly Day, Ye

Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma		artment of Healt		ental Hygien	е	
			Registrar  1. Decedent's Name (First, Middle	o ( oot)	Cer	tificate of Deati		Reg. N	10. 201	1, 37204
	Physicia	n/	John						ay Year	3. Time of Death 4:30A M
	Medic Examin		4a. Facility Name (if not institution	Graham  n, give street and number)		4b. City, Town, or Location	ion of Death	November	c. County of Deatl	
7	Examili	C1	916 M	Franklin	Atrost	Rais	timo		c. County of Death	
	Funeral		5. Social Security Number	6. Sex 7. Age	(In yrs. last birthday)		der 24 Hrs.	8. Date of Birth		hplace (State or Foreign
	Director		215-28-9858	1 ■M 2 □ F	ΠQ Yrs.	Months Days Hour	rs Min.	(Month, Day, Year)	- 100	intry)
	nd now at	Ļ	Usual Residence of Decedent 10a, State 10b, County	,	10c. City, Town or Loc	eation		2 12/14	32   Vor	10d. Inside City Limits
	arylar a-f sl	ecto	AAA	1 1	Ra	( 1 )				1 Yes 2 □ No
	or 28 or 28	Ö	10e. Street and Number	117	10 KC	10f. Zip Code		10g. C	Citizen of What Co	untry?
	with t	Funeral Director	916 10	Franklin	Street	212	202		110	2.4
	death items ier m		11. Marital Status	12. Was Decedent Ev Armed Forces?		Vas Decedent of Hispanic Yes, specify Cuban, Mexi			14. Race - Amer	
36	after or '', or camin	l by	1 Never Married 2 Ma	rried 1 Yes 2 1	No I	Yes 2 No Spec		ouri, oto.)	Black, White	e, etc.
21215-0036	atura cal Ex	Completed	3 Widowed 4 Divorced	Year or Dates.	16a Deced	ent's Usual Occupation		Tack		lack
715	an "n Medi	mp		est grade completed)  College (1-4 or 5-	(Give I	kind of work done during n O NOT use retired)	most of working	7	Kind of Business/	industry
	withii giene ser th t, the		2	College (1-4 of 54	·	Check	Lev		Rail	road
Maryland	Id be filed within 72 hours after death with the Manyland Mental Hygiene arked other than "natural", or items 23a or 28a-f sho artic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle,	Λ		18. M	lother's Name	(First, Middle, Maider	n Surname)	,
ry la	should be and Men is marke raumatic	-	Jahn	Graham			Sa	My B	pennet	-st
Ma	2 shou th and 27 is m traum	1 8	19a. Informant's Name/Relations	$\nabla = (\Delta)^{-1}$		g Address (Street and Nui	mber or Rural	Route umber, City o		_ 1
	I and I Heal		20a. Method of Disposition	ha Graha	20b. Place of Dispo		KUIN DE	ate 20c.	Location - City or	10 21223 Town, State
m0	Page 1 ment of ant; If it ury or o		1 Nation 2 Cremation 4 Donation 5 Other		Garrisa	natory or other place)	101	L. M	wings	Mills MD
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	1	21. Signat Funeral Service		22		acility O	111	rai Hor	, ,
m	De la la la la la la la la la la la la la		* Odysser	y Hay	2	20 seph	iorth	Aw. B		ND 21216
			23a. Part 1. Enter the disease of shock, or heart failure. List	r complications that caused only one cause on each line.	the death. Do not ente	r the mode of dying, such	as cardiac or	respiratory arrest,		Approximate Interval Between
2	Phylin	1	Immediate Cause (Final disease or condition	End-	Stage Car	diomyopathy	)			Onset and Death
-	Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
		Jer	Sequentially list conditions, if any leading to immediate	b. — Due to (or as a	consequence of):					
	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
	exectan an an arial-tr	Ĕ	resulting in death) Last	Due to (or as a	consequence of):		-			
09	cate be executed physician and s the burial-transit	edical		d						
687	ertifica ding p	/We	IF FEMALE:	23c. If yes, outcome of	of pregnancy					
×o	ath ce attend for us	cian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy Other (specify)		3	23d. Date of del Month	ivery Day Year
Division of Vital Records, P.O. Box 68760	the de y the ached	Physician/M	1 Yes 2 No 9 Unknown	9 🗌 Unknown						
Ρ.	that I	by Р	Part II. Other significant condition	ons contributing to death bu	at not resulting in the u	nderlying cause given in P	Part I.	23e. Did tobacco	use contribute to	the cause of death?
ds,	quires en sig ould b							1 🗆 Yes	2 √No 3 □ Pi	robably 4 🗆 Unknown
CO	law re las be	Completed						24a. Was an autopsy	prior to o	topsy findings available completion of cause of
æ	: The cate h							performed 1 Yes 2 1	death?	2 🗆 No
ita	sician certifi irecto	Be o	25. Was case referred to medical examiner?  1  Yes 2  No	Hospital:		Other	Death (Check o	-		
کر د	Physer this eral d	e: 10	27. Manner of Death	28a. Date of injury	nt 2 ER/Outpatier y 28b. Time of	28c. Injury at		ne 5 Residence		ify)
UC.	nding ath. r: Afte ie fun	icat	1 Natural 5 Pendi 2 Accident Invest	ng (Month, Day,	Year) injury	work? M 1 □ Yes 2			ary coodings	
isi	er degreector	Certificate:	3 Suicide 6 Could 4 Homicide determ		ry - At home, farm, stre	eet, factory, office	21	8f. Location (Street a		ral Route Number,
<u>S</u>	ital or urs aft ral Dir			building, etc.	(Opecity)			City or Town, Stat		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Medical	(Check 2 L Medical	g Physician: To the best of n Examiner: On the basis of ex	amination and/or invest	igation, in my opinion, deat	th occurred at the	ne time, date and place	ce, and due to the	cause(s) and manner stated.
	ithin ithin or the omple	Σ		g Nurse Practitioner: To the	best of my knowledge,	death occurred at the time.  29c. License number			se(s) and manner a pate signed (Month	
	- s i o		► MS Rajaj	oan(M.D		00057			11/18/1	
-	7		30. Name and address of person	who completed cause of de	eath (Item 23a) (Type, F				111	2 6
			N.S. Rajapakre			AV SZO3	Da	impre	12 CM	(0)
	Stat Registra		31. Date filed (Month, Day, Year) NOV 2 2	32. Registrar	r's Signature	Les 1				
	- Collectif		1101 70 70	- North	1 1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 37202 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lance Collins 2011 11:10 PM November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death <u>18816 Heritage Hills Drive</u> Brookeville Montgomery If Under 1 Year If Under 24 H 8. Date of Birth (Month, Day, Year) Apr 5, 1944 ocial Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months 1 ★ M 2 □ F Hours New Zealand Director Yrs 213-54-9799 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Arlington Arlington 1 Yes 2X No VA 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1860 N. Scott Street 22209 USA an "natural", or items Medical Examiner mu Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give ģ 1 Never Married 2X Married Maryland 21215-0036 1 Yes 2X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ the Journalist Newspaper permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Landseer John Collins Gay Grace Elizabeth Harvie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20505 Riggs Hill Way Brookeville, MD 20833 Valerie Lynn Carlson/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Woodbine, MD Final Journey Crematory 11/22/11 4 Donation 5 Other (Specify) Signature of Funeral Service Licer Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Chronic Obstructive Pulmonary Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate Examine Due to (or as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Year Month Day Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2X No certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Wife's 1 Yes 2 XNo Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Sp. After this home within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral is 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work?
1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 1XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, ueau occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) November 21, 2011 D37142 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Geoffrey Coleman, 1355 Piccard Dr. Rockville, MD 20850 M.D.

State Registrar 31. Date filed

32. Registrar's Sig

11-08630

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Thomas (	JIE6	1- For State Registrar	/ Departmen <i>Certificate</i>			Mental H	R	eg. No. 2	014 372
Physicia al Exami		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	nth Day Year r 16, 2011	3. Time of Death 2152 hrs
		Justin Thomas Greenbank  4a. Facility Name (if not institution, give street and number	•)	4t	. City, Town, or Lo	cation of Death	Novembe	4c. County of	
		15 East ninth Street  5. Social Security Number 6. Sex 7. A.	ge (In yrs. last birthda		Frederick  If Under 1 Year	If Under 24Hrs	8 Date of Riv		Birthplace (State or
uneral irector		213-23-9289 1XM 2F	22	Yrs.	Months Days	Hours Min.	7		Foreign Country)Maryland
'n		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocatio	n				10d. Inside City Limits
show a	L	Maryland Frederick	Frederic						1 Yes 2 No
8a-fs	cto	10e. Street and Number	Treating		10f. Zip Code		1	Og. Citizen of Wha	at Country?
tn the Maryland 23a or 28a-f sho ootified at ooce	Director	15 East ninth Street			21701			United	States
items 23	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces	?		Decedent of Hispa s, specify Cuban, N			14. Race - White,	American Indian, Black, etc.
l", or		3 Widowed 4 Divorced If Yes, Give Year	2 K No 1	1 🗌 🕥	res 2 No s	specify:		Specify:	WHITE
atura	d by	15. Decedent's Education (Specify only highest grade co			Usual Occupation			16b, Kind of Busi	iness/Industry
any 2 shows to size, when the grant of the shows are used with the probay shall teath and Mental Hygiene.  ten 27 is marked other than "oatural", or items 23a or 28a-f she traumatic eveot, the Medical Examiner must be softlifed at once	Completed	Elementary/Secondary (0-12) College (1-4 or 12	5+)	-	Server	O NOT use let	64)	Restau	ırant
h and Mental Hygiene.  27 is marked other than matic eveot, the Medica		17. Father's Name (First, Middle, Last)			18.	.Mother's Name	(First, Middle,	Maiden Surname)	
Mental I	o Be	UNKNOWN  19a, Informant's Name/Relationship (Type, Print )	10b M	lailina i	Addrona (Street o		Bailey	mber, City or Town,	State Zin Code)
Point rages I am a snough Department of Health and Me Important: If item 27 is ma iojury or other traumatic ev	ř	Mickey Henderson - GRANDMO						olina 279	
Health item 2		20a. Method of Disposition	20b. Place of Di	ispositi	on (Name of ceme		Date		City or Town, State
nt of I		1 Burial 2 Cremation 3 Removal from S			natory IN	IC 11-	18-2011	l Balti	more, Marylan
artme ortan		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee							of Maryland IN
		Votet millem	ina 1	299	Frederic	ck Road.	Baltin	more Marv	land 21228
and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a constitution of the constitution o							
sician and	edical	d.  MENDED AMENDED 23a	,27,28a-f	, pe	r me,g923	3 1-9-1	2 sm		
ine iaw requires that the death certaicate rate has been signed by the attending physioage 2 should be detached for use as the bu	2	23b. Was decedent pregnant in the past 12 months?	me of pregnancy  t time of death  2  5	_	I death 3	Ectopic pregna		23d. Date of d Month	Day Year
igned by	ģ	Part II. Other significant conditions contributing to dea	th but not resulting in	the un	derlying cause give	en in Part I.			ute to the cause of death?  Probably 4  Unknown
ite has been s	Completed						24a. Was autop perfo	osy pri ormed? de	ere autopsy findings available or to completion of cause of ath?  Yes 2 No
his certificate director, page	Be C	25. Was case referred to medical		3	26.Place of	Death (Check			
this ce	.0	examiner?  1 Yes 2 No Hospital: 1 Inpati	ent 2 ER/Outpa	atient	3 ☐ DOA Ot	her Nursin	g Home 5	Residence 6	Other: Scene
After	ion: T	27. Manner of Death  1 Natural 5 Pending 28a. Date of Inj (Month, Day,	at Work?			ymorphone and			
within 24 hours after death.  To the Fuoeral Director: After t completely filled in by the funeral	Certification:	3 Suicide 6 Could not be	njury - At home, farm, ound: Resid	street,	factory, office buil	ding, etc.	28f. Location (	Street and Number State) 15 Eas	or Rural Route Number, City  t Ninth St.
in 24 hou he Fuoer pletely fil		29a. Certifying Physician: To the best of no cone)  2 Medical Examiner: On the basis of examiner:			- market and a second		due to the caus	se(s) and manner a	
within To the comple	Medical	and manner stated  29b. Signature and title of certifier			29c. License n		, -0.0		(Month, Day, Year)
1		MA L		l	О.С.М.			November 1	
Bu h		30. Name and address of person who completed cause of Russell Alexander MD. Assistant Medic	deeth (Item 23a) cal Examiner 9	900 V	/. Baltimore St	treet, Baltim	ore, MD 21	223	
St	ate	31. Date filed (Month, Day, Year) 32. Registra	ar's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1100 7008 Medical Hovember 4a. Facility Name (if not institution, give street and number) 4b City, Town, or Location of Death **Examiner** 4c. County of Death 14 more **Funeral** 24 Hrs. Min. 8. Date of Birth 9. Birthplace (State or Foreign 70-860 Hours (Month, Day, Year) 1 1 4 2 D F Director (rainia or 28a-f show 10b. County 10c. City, Town or Location any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Xos 2 No 10f. Zip Code 10g. Citizen of What Country? or items 23a by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces ⊥ Yes 2 No Yes, Give Black, White, etc wer Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify "natural". Completed 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industr (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4 or and 2 should be filed with Health and Mental Hygien em 27 is marked other t Be Father's Name (First 18. Mother's Name (First, Middle, Maiden Surname ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Department of Health Important: If item 27 was 20b. Place of Disposition (Name of cemetery, crematory or other d of Disposition Date 20c Location - City or Town, State Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) of Funeral Service Licensee se, or complications that caused the death. Do not enter the mode of dyng, such as cardiac or respiratory arrest, List only one cause on each line. Approximate shock Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ,0515 Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 the h as use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death P.O. s been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autonsy 1 Yes 2 No Yes 2 1 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury I hours after death.
uneral Director: Aft work? 1 ☐ Yes 2 ☐ No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a. Certifier Exterifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of g 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Baltimore M60 31. Date filed (Month, NOV 2 2 32. Registra s Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Gasparyan 9:20 M Misha Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 15+19201 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1**X** M 2 □ F Months Days Hours (Month, Day, Year) 58 Director 09 Arménia Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 No Baltimore NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
Armenia 21209 6911 Jones View Drive #30 Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2X Married þ ☐ Yes 2 🔀 No filed within 72 hours after Rimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Divorced 4 Divorced Completed Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Unemployed 4yrs Unemployed 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Suren Gasparyan Yepraqsia Gasparyan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21209 Jones View Drive #3C, Baltimore, Md Alisa Javadyan-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Druid Ridge 11/19/2011 Pikesville, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funda Service Service 22. Name and Address of Facility March F/H West |4300 Wabash Av Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 20 No Month Year Pregnant at time of death Day sate has been signed by the page 2 should be detached 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 2 🗌 No ☐ Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 Yes Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5  $\square$  Pending 1 🗌 Yes 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4  $\square$  Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1812 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo WD

DHMH 17 Rev 7/2009

State Registrar 21215

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 19, 2011 November 2:10  $A^M$ RICHARD PAUL GRAZIANO, SR. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Burtonsville Montgomery Sanctuary at Holy Cross 8. Date of Birth
(Month, Day, Young)
July 22, 9. Birthplace (State or Foreign Country) Wash., DC If Under 1 Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) **Funeral** . 1<u>935</u> 1 😿 M 2 🗆 F Director 214-32-8679 76 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shou any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any ence. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 No MD Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8306 Sand Cherry Lane 20723 U.S.A. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No 1955 Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify:White If Yes, Give 3 Widowed 4 Divorced Year or Dates. -195716a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Grade 12 PEPCO Foreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Pasquale Graziano Carmella Cintrano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn V. Graziano spouse 8306 Sand Cherry Lane Laurel, Maryland 20723 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory: 11/22/2011 Odenton, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue 20707 Laurel, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tonly one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. L Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ ATIO disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner DYTEUT Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying sician and burial-transit Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Unknown 1 Yes 2 No signed by the a Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nonknown cate has been sig page 2 should b Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? certificate 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No 2 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11/21

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

MEND TITEM 5 Perfil (922, 12/16/2011, WS)

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 9:25pm M Physician/ November 20 ay 2011 Year Catherine G. Gullace Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Oak Crest Care Center Parkville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral June 22 1925 1 □ M 2 □ F Months Days Hours Min. 86 Rochester, New York Director Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location with the Maryland **Funeral Director** Maryland Baltimore Parkville 1 Yes 2 No 10f. Zip Code 21234 10g Citizen of What Country? 10e, Street and Number 8820 Walther Blvd. # 4311 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify 3 Divorced 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Department of Health and Montal Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event". (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeping-Own Home 12 N/A Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Delores Giovine Thomas Giarrizzo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8820 Walther Blvd. # 4311 Parkville, Maryland 21234 Anthony Gullace (Husband) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. John's Church Cemetery, Nov. 23 2011 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State Hydes, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee <sup>22. Name, and Address of Facility Lassann Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236</sup> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ng physician and as the burial-transit or Attendir g Physician: The law requires that the death certificate be executed Cause (Disease or lingury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery Division of Vital Records, P.O. Box in the past 12 months?

1 Yes 2 No
9 Unknown Į0 Month Day Year page 2 should be detached the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Whiknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: Other Specify 2. No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA furreral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Af nours at er death.

neral Director: Af
I filled in by the fur 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completed fi Exertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed car se of death (Item 23a) (Type, Print) 32. Registr State Registrar

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			For State Registrar	State of Maryla		artment of Heal <i>tificate of Dea</i>			001	27200	
			Decedent's Name (First, Middle, Last,	)		timouto or boa		2. Date of Death	. No. 20	3. Time of Death	
	Physicia Medio		Vernon F.					Nov. 18,	2011 Year	1:00 P M	
	Examin	er	4a. Facility Name (if not institution, give s William Hill Ma			4b. City, Town, or Loca	ation of Death		4c. County of Deal	bot.	
-	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs	s. last birthday)	If Under 1 Year   If U	Inder 24 Hrs.	8. Date of Birth	g. Bir	thplace (State or Foreign	
	Director		216-20-2848	<b>Ж</b> м 2 □ F	84 Yrs.	Months Days Ho	urs Min.	$\text{May}^{\text{(Month}}24, \text{Ye}$	1927   Mar	y Yand	
	and show at	or	Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Lo	cation				10d. Inside City Limits	
	Maryli 28a-f otifiec	irect	VA Loui	sa		Miner	al			1 🗆 Yes 2 🎞 No	
	th the 3a or t be n	al D	10e. Street and Number			10f. Zip Code	447	10g	g. Citizen of What Co		
	ems 2	Funeral Director	71 Linda Lane	12. Was Decedent Ever in I	U.S. 13. V		117 ic Origin? (Spec	cify Yes or No-	US 14. Race - Ame	-	
92	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		1 Never Married 2 X Married	Armed Forces?  1 Xyes 2 No	.	Nas Decedent of Hispani f Yes, specify Cuban, Me I ☐ Yes 2 ◯XNo Spe		Rican, etc.)	Black, Whit	e, etc.	
8	ours a ntural'	eted	3 Widowed 4 Divorced  15. Decedent's Ed.	Year or Dates. WWI			ecny:			White	
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Maryland 21215-0036	ild be filed Mental Hy larked oth	To B	17. Father's Name (First, Middle, Last) Dr. E. A. F. Grem	nler			Mother's Name <b>Margare</b>	(First, Middle, Maio et Mahon	,	*	
ary	2 should be fil th and Mental ?7 is marked traumatic ev		19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Address (Street and N				p Code)	
Σ	스 든 12 후		Ginger Ball/Daugh	ter		Corbin Pkw			yland 216		
Baltimore,			20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ I	Removal from State	. Place of Dispo cemetery, cren	natory or other place)	1		c. Location - City or		
ţ	コキモニ		4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Setvice License			ge Cemetery  Name and Address of F			ltimore, Funeral F	•	
Ba	permit Depar Impor any ir		1 miles	Mull					Maryland		
			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only on	ications that caused the de e cause on each line.	eath. Do not ente	er the mode of dying, suc	ch as cardiac or	r respiratory arrest,		Approximate Interval Between Onset and Death	
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		Medi	IF FEMALE:								
89 x	eath certific attending p I for use as	ian/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg	etal death 3 🗌	Ectopic pregnancy			23d. Date of de		
Box	ne dea / the a	Physician/M	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time og ☐ Unknown	of death 5 ∟	Other (specify)			Month	Day Year	
Division of Vital Records, P.O.	ttending Physician: The law requires that the des death.  toor After this certificate has been signed by the a funeral director, page 2 should be detached to the funeral director, page 2 should be detached to the funeral director.		Part II. Other significant conditions con				Part I.	23e. Did tobac	co use contribute to	the cause of death?	
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Vita	is cert direct	To Be	evaminer?	lospital:	☐ ER/Outpatien	Othors	Death (Check		e 6 🗆 Other (Spec	ify)	
of	ing Ph viter th uneral		27. Manner of Death 1 ♣ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?	2	8d. Describe how i			
sior	Attend death ctor: A y the f	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	home farm stre	M 1 ☐ Yes		29f Location (Street	t and Number or Ru	ral Pouto Number	
Ö	al or A s after al Direction by	Se	4  Homicide determined	building, etc. (Spec	cify)	set, factory, office	1	City or Town, S		rai noute Number,	
_	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  within 24 hours after death.  to the Funeral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examin	cian: To the best of my kno er: On the basis of examinat	owledge, death o	occured at the time, date	and place, and	due to the cause(s	s) and manner as sta	ated. cause(s) and manner stated.	
	o the l	Me	only one) 3 Certifying Nurse  29b. Signature and tible of certifier	Practioner: To the best of	my knowledge, o	death occurred at the time, 29c. License numl	, date and place	e, and due to the cau	use(s) and manner as  Date signed (Mont)	stated.	
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	Registra		MA 5 5 501.	2. Registrar's Sign	a. ya	Ke					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November Physician/ 1:20 PM Walter Edward Gross, Jr. 2011 16 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Haurel )e Grace 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sex 1XXM2□F Hours 03/2474926 Marviand 85 **Director** 216-20-9728 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 🎗 Yes 2 🗆 No Harford Aberdeen Maryland 10e. Street and Number 10f. Zip Code ō 10a. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 224 Graceford Dr. 21001 USA Page 1 and 2 should be filed within 72 hours after death unent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces?

1 XYes 2 No 1945-Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. 1946 Specify: White Completed 3 Widowed 4 Divorced and Mental Hygiene.
is marked other than "natu
aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) US Government Civil Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Alberta Parks Walter E. Gross, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma S. Gross (wife) 224 Graceford Drive, Aberdeen, MD 21001 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 🛮 Burial 2 🗀 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Paul's Cemetery 11/22/11 Aberdeen, Maryland 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 21. Signature of Funeral Service Acensee Maryland Aberdeen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that in the cause (Disease). Examiner Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Year Pregnant at time of death t een signed by the signal be detached 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an Spectension page 2 s has autopsy performed certificat 2 1 **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 N ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred After 1 Watural iniury 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director; A

completed filled in by the f Suicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20215 11

Registrar

State

31. Date filed (Month, Day, Year)

NOV 22

DHMH 17 Rev 7/2009

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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601.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month -14-2011 3:50 P M GREGORY VTOLA. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE OVERLEA HEALTH AND REHAB CENTER ear If Under 24 Hrs. ays Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 🖪 Country) 10-13-1941 Director 70 MD Usual Residence of Decedent show must be notified at 10b. County 10c. City. Town or Locati 10d. Inside City Limits Director BALTIMORE 28a-f Yes 2 □ No 10e. Street and Number 0 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 2803 PRESBURY ST 21216 USA items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Examiner Armed Forces , or by 1 Never Married 2 Married 1 Yes If Yes, Give 2 XNo Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK "natural", 3 ₩ Widowed 4 □ Divorced Completed Year or Dates Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HOUSEWIFE HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be COLUMBUS CASEY SARAH MILBURN other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a: If item 27 is **EUGENE CASEY/SON** and 2 904 GARDEN DR., APT 2A, ESSEX, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Page 1 permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11 - 19 - 11 BALTO., MD METRO CREMATORY 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signeture of Funeral Service Licensee James a.w 1701 LAURENS ST., BALTO., MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician disease or condition Medical resulting in death) Due to (or as a sequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transit Due to (or as a consequence of): resulting in death) Last physician Physician/Medical that the death certificate be Box 68760 the use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? 1 L Yes 2 No 9 Unknown Month Day Year Pregnant at time of death the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> pe of Vital Records, 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 1 Yes 2 No Hospital or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death.

Funeral Director; After (Month, Day, Year) 1 Natural 5  $\square$  Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and

State Registrar 5661-6 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 2011

Paven Bluel, Baltimore

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		-	For State		State of Ma	aryland /	Department of		d Mental Hy	giene	1 27211
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The Marie	Physicia: Medic	al .	Sue	13	len	-	tollman		Month	2Day 2	011 12:30 PM
	Examine	er	4a. Facility Name (if not in	Mari	1	Spic	-	n, or Location of Dea		4c. County of E	Death Ltimore
F	uneral		5. Social Security Number			e (In rs. last bir	thday) If Under 1 You		rs. 8. Date of Bir	th g.	. Birthplace (State or Foreign
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	", or i	۵	1 Never Married		Armed Forces?  1 Yes 2 If Yes, Give	No	1 Yes, specify C	/	епо нісап, етс.)	Black, V Specify:	White, etc.
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<b>215</b>	an "n Medi	d l		nly highest grade			(Give kind of work do life. DO NOT use reti	one during most of w	vorking	16b. Kind of Busin	ess/mustry
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Maryland 21215-0036	ed otl	To Be	17. Father's Name (First,	Middle, Last)	1 - ++			18. Mother's N	Name (First, Middle,	Maiden Surname)	1
Adryland should be file	mark		19a. Informant's Name/F	Relationship (Typ	e, Print)	19	b. Mailing Address (Str	reet and Number or	Rural Route Number	er City or Town State	z Zio Code)
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Balti Permit.	Important: I any injury or once.		21. Signature Funcial	Service Liversee	Huris	1.44	22. Name and Ad	ddress of Facilit	uss Fu Ave. E	salto, M	D Me, P.A.
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of ing Pi	After th		27. Manner of Death Natural 5	Pending	28a. Date of inju (Month, Day		injury	Injury at work?	28d. Describe	how injury occurred	
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Division of Vital Records, P.O. Box 68760 to the Hospital or Artarding Physician: The law requires that the death certificate	when the Function steer occurs.  To the Funeral Director.  completely filled in by the funeral director, page 2	Medical	(Check 2 🔲 🐧	Medical Examine	er: On the basis of e	xamination and/		opinion, death occurre	ed at the time, date	and place, and due to	the cause(s) and manner stated.
o the	Fo the	Σ	only one) 3 12 29b. Signature and atle		Practitioner: To th	e best of my kno	owledge, death occurred	d at the time, date an cense number	a place, and due to	the cause(s) and man 29d. Date signed (A	
			> //	MARIE	2 O AM	0	R	14974	2	11/2/12	011
			30. Name and address o	person who co	mpleted cause of d	eath (Item 23a)	(Type, Print)	1/	1) =	11-11-0	
À			JACKIE	Jones	CRNP	2300	Du gue,	Valley	kd Yimm	M. Musica	D 21093
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ Month 12:574 ae Medical 4b. City, Town, or Location of Death **Examiner** County of Death Baltimore WSON Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min **Director** M 2 🗆 F 58 mi Usual Residence of Decedent 28a-f show 10a. State County 10b. 10c. City, Town or Location must be notified at 10d. Inside City Limits Director mi 1 Yes 2 No ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 21093 death v Was Decedent Ever in Armed Forces?
1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ŏ þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify "natural", Dlac Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) ptailer Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 20b. Place of Disposition cometery, cremator of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service 22. Name and Address of Facility any ir rene Funeral Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Atheroscherche Immediate Cause (Final Physician Cardiovascular 1) ISRASE disease or condition resulting in death) minutis Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day Year signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No page this certificate 2 🛮 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 1 Inpatient 2 K ER/Outpatient 3 IDOA မ 4 Nursing Home 5 Residence 6 Other (Specify) the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04315 77,2011

Registrar

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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(Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day **Physician** 1626 PM Robest Hens) 2011 November 19 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hospital Baltimore Northwest RANDALLSTOWN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, . Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Days Hours Months M 2□F Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be modified at 1 ☐ Yes 2 No MD Baltimore **Funeral Director** JWNN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Wilmont Drive, Apt. 103 21207 12. Was Decedent Ever in U.S. Armed Forces? 1 Dres 2 □ No Ifres, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Health and Mental Hygiene. em 27 Is marked other than Elementary/Secondary (0-12) Factory Laborer 9th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LUIK Be Gadson Julia 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other trau once. Gwynn Oak MD 21207 Margaret E. Henri 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 1201/2011 Garrison Forest Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Valighn C. Green Furteral Services 21. Signature of Funeral Service Licensee 8728 Liberty foad Randallstown MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he int failure. List only one cause on each line. Immediate Cause Final disease or condition resulting in death) **Physician** Soke /Medical Due to (or as a consequence of): Examiner neum Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1  $\square$  Live birth 2  $\square$  Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 Other (specify) signed by the a I be detached fo P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page this certificate 1 ☐ Yes 2 ☐ No 2 - N To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) After thi funeral 27 Manner of Death 28h Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation ours after death.
neral Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 6493 November 19, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NILESH PATEL NORTHWEST HOSPITAL, RANDALISTOWN, MD MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Пау Physician/ Year Month 2011 1530 19 Hilliard Medical Grace November 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Harkord Havre de Grace 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number **Funeral** Days 1 □ M 2 🗓 F Months Hours Min Director 213-38-8578 101/1916 Ponnsulvania Usual Residence of Decede or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No <u>Harkord</u> Havre de Grace ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral Congress Avenue Api 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, er than "natural", or iter the Medical Examiner Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Completed by Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify. White 3 Widowed 4 □ Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working th and Mental Hygiene. 27 is marked other than " traumatic event, the Med life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hamomabox Home Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ George Arthur Davis Mary Thomas I and 2 should b I Health and Mer Item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Revolution St.. George DeCamillis (Son) Apt. 501. Havre de Grace. MD Important: If item 2 any injury or other t 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State 5 cemetery, crematory or other place) 4 Donation 5 Other (Specify) .Ferris & Co.Inc. 11/22/2011 West Chester, PA algnature of Funeral Service Licensee 22. Name and Address of Facility Zellman Funeral Home, P.A. 123 S. Washington Street, Havre de Grace, MD 21018 Fart 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only of the cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ 1 ane pen ade 11-1511 disease or condition Medical resulting in death) Examiner 11-15-11 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy performed this certificate 1 ☐ Yes 2 ☐ No Yes 2 Hospital or Attending Physician: funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 4 No 1 🗌 Yes Medical Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation hin 24 hours after deal the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number completed filled in by determined 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 11-21-11 M.D. HAURE DE ERACE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NON BVE 2 32. Regis State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Rose Ida Hopkins 9:00 A M November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2519 Running Wolf Trail Odenton Anne Arundel Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Min. Director 88 Maryland August 217-16-1340 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21113 United States 2519 Running Wolf Trail 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc Hygiene. other than "natural", or ğ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. White Completed 3 Widowed 4 Divorced Specify: Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th 12 Cook Restaurant injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) <u>James D. Hopkins</u> Alice Peddicord 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a James M. Arnoldt/Son permit. Page 1 and 2 Department of Health Important: If item 2; any injury or other th 2519 Running Wolf Trail, Odenton, Maryland 21113 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) West Arundel Crematory 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State November 20 4 Donation 5 Other (Specify) Odenton, Maryland 2011 . Signature of Funeral Service Licenseé 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. CED M01386 1411 Annapolis Road, Odenton, Maryland 21113 Part 1. En er the disease, or conshock, or his mure. List only lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Months lure. List only on Immediate Cause (Final Physician/ disease or condition Myocardial Infarction Medical resulting in death) Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Anemia, Hypothyroid 1 ☐ Yes 2 ☐ No 3 😾 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Smoker autopsy death? Physician: The 2 No Yes 2 X No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 XNo ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death ne Hospital or Attending Pl in 24 hours after death. The Funeral Director: After the pleted filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town. State) Medical 29a. Certifier 1 😾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🛄 Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse randoner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of person w

Lee,

M.D.,

Danny E.

o

ed cause of death (Item 23a) (Type, Print)

D54853

1132 Annapolis Road, Suite 204, Odenton, Maryland 21113

November 18, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ HAYWOOD Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brooklyn Bridge Road Prince George's Laurel 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, Year) 1 🗷 M 2 🗆 F Director 220-28-7662 79 Mar. 28, 1932 Maryland Usual Residence of Deced 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2XX No MD Prince George's Laurel 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? must be or items 23a Funeral 7602 Brooklyn Bridge Road 20707 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 hours after 1 ☐ Yes 2 🛛 No Specify: "natural", White 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Research Technician 12th Paper Mill traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Department of Health and Mont. Important: If item 27 is marked any injury or other. Erlon Haywood Teresa Droppelmen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Haywood/Wife Brooklyn Bridge Road, <u>20707</u> 7602 Laurel, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) West Arundel Crem. :11/15/2011 Odenton, MD Donaldson Funeral Home, P.A. of Funeral Service License 22. Name and Address of Facility 313 Talbott Avenue, Laurel, Enter the disease, or complication of leart failure. List only one eat is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Betweer et and Douth Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical phys the b P.O. Box 68760 ending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) the £ signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s perform certificate 2 Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending after death. 1 Yes 2 No Investigation Accident Suicide 6 Could not be n 24 hours after der e Funeral Directo bletely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completely fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Descritifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month, Day, Year) 10 Dause of death (Item Ba) (Type, Print) Name and address of person 1X ANDAPOLIS M.D. 21401

State Registrar 32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2°011 JOHN CLARK HOEN 12:00 AM ovember Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Regional Hospital Prince George's Laurel Ldure If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth OCT 18, 1934 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🛛 XX/1 2 🗆 F Months Days Hours Min. Country York 071-32-1224 Director Usual Residence of Decedent 28a-f shov 10b. County at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified 1XXYes 2 No Laurel Maryland Prince George's 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20707 U.S.A. 7607 Erica Lane 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? 1 ☒ Xes 2 ☐ No If Yes, Give Black, White, etc. "natural", or ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXVo Specify: 3 Divorced Specify White Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "I Elementary/Seconday (0-12) College (1-4 or 5+) DOD years Anlayst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mildred Clark John G. Hoen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st. Department of Health ar Important: If item 27 is any injury or other trau Laurel, Maryland 7607 Erica Lane Carol R. Hoen spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 XXremation 3 Removal from State cemetery, crematory or other place. 4 Donation 5 Other (Specify) Arundel Crematory 11/19/2011 Odenton, Maryland 21. Signature of Funeral 3 ryice Licensee 2Donardsons Funeral Home, P.A. / M00770 313 Talbott Avenue Laruel, Maryland 20707 23a, Part 1, Enter the disease. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List Interval Between Sepsis Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day the 9 Unknown Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Diabetes Mellitus Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Acute Renal Failure 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy perform this certificate Yes 2 No Division of Vital : After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 **V** No 1 Yes မြ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manney of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A

completed filled in by the f 2 Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier November 17, 2011 ら<sup>X</sup> 7300 Van Dusen Road of person who completed cause of death (Item 23a) (Type, Print) Saritha MD Regional Gorantia Laurel 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

aniel Kelly Hartn	1	- For State	State of Maryl	and /		irtment of <i>tificate</i> o <i>f</i>			Menta	al Hyg		Reg. No.	20	3721
Physician	_	tegistrar 1. Decedent's Name (First, Mic	Idle,Last) Danie	1 Ke	11y	Hartman	n JR.			2	. Date of Dea	ath	Voor	3. Time of Death
/ledical Examin		DANIEL KELLY	HARTMAN	, JR	-						Month Novembe			0609 hrs
		4a. Facility Name (if not institu 1435 Washington A		umber)		4	b. City, To Severr	-	ocation of	Death			County of Dea	
Funeral Director		5. Social Security Number 214-94-3225	6. Sex			ast birthday)	If Under Months	_	If Under Hours	Min.			Fore	irthplace (State or ign ountry) MD
	ŀ	Usual Residence of Decedent	1 <u>k.z</u> ,m 2_ F	4	16	Yrs.		<u> </u>		<u> </u>	Dec. 3	S, 19	064	, MD
any .		10a. State 10b. Count	у	1	0c. City,	Town or Locati	on							10d. Inside City Limits
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a or Sa or		1435 Washingt	on Avenue				21	144				U.S	S.A.	
h with	<u>e</u> a	11. Marital Status	12. Was De		ver in U.		s Deceden				ecify Yes or No- 14. Race - American Indian, Black			erican Indian, Black,
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21215-00; ould be filed with a Mental Hygiene, marked other the cevent, the Med		17. Father's Name (First, Midd						11	8.Mother's	Name (	First, Middle,	Maiden	Surname)	<del></del>
121 d be fi lental arked svent,	8	Daniel K. Har 19a Informant's Name/Relatio		Mario						aughn	mbaa Ci		to Zin Cada)	
MD 21215-0036 nd 2 should be filed within alth and Mental Hygiene m Z7 is marked other than a marked other	۱٩			hrot	hor	16.		•						
Imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Iant: If Item 77 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner, must be notified at once.	Ronnie Steven Hutson / brother   7687 Oak Lane Pasadena, Maryland 21   20a. Method of Disposition   20b. Place of Disposition (Name of cemetery,   Date   20c. Location - City										L 2 2 or Town, State			
DOF ages 1 at of F other	-	1 Burial 2 Xxcremation 3 Removal from State crematory or other place)  W. Arundel Crematory 11/21/2011 Odenton									lenton.	Maryland		
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and In Important: If Item 27 is ur	ŀ	4 Donation 5 Other Specify: W. Alt Midel Clematory 11/21/2011 Odelitor, M. 21. Signature of Funeral Service Licensee  22. Name and Address of Facility Donaldson Funeral Home, P.A.										77		
Dep Dem 📆	- 1	/ M00770   313 Talbott Avenue Laurel, Maryland										nd 20707		
Physician		23a. Part I. Enter the disease, failure. List only one cau		caused th	ne death.	. Do not enter th	ne mode of	dying, s	such as car	rdiac or i	respiratory a	rest, sho	ck, or heart	Approximate Interval Between Onset and
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	-	or condition resulting in death)  Due to (or as a consequence of):												
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):													
	Examiner	cause. Enter Underlying Cau- (Disease or injury that initiated	1 <sup>C.</sup>	a consec	uence o	f)·			-					
Tansit.	ШÄ	events resulting in death) Las	d.			•								
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760, cate be physici	ĕ,	IF FEMALE: 23b, Was decedent pregnant in	23c. If yes	, outcome			12-21	_11	_			23d	. Date of delive	
OX 6876	Ä	past 12 months?	I L LIVE	birth gnant at ti	me of de		tal death her (S <i>peci</i>	3 <u></u>	Ectopic	pregnan	су	1	Month	Day Year
Box 6876  e death certificate the attending phy ed for use as the b	Physician/M	1 Yes 2 No 9 L	Jnknown 9 Unk	nown		□ 0t	nei (opco							
P.O. BO)	2	Part II. Other significant con	ditions contributing	to death	but not re	esulting in the u	inderlying (	cause gi	ven in Par	t I.				to the cause of death?
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COF law r has b	힐		-								per	opsy formed?	death'	
tal Reclan: The certificate		25. Was case referred to med	ical				2	6 Place	of Death (	Check or	1 Yes	2 N	1 🗸	Yes 2 No
Division of Vital Records, rs afterding Physician: The law require rs after death. In the two restricts that birector: After this certificate has been silled in by the funeral director, page 2 should be	۵,	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatien	t 2	ER/Outpatient	3 DC	OA C	Other <sub>4</sub>	Nursing	Home 5	Reside	nce 6 🗸 Ott	ner: Scene
n of \ding Phy	읽	27. Manner of Death	28a. Dat	e of Injur	y ar)	28b. Time of I	njury 2	Bc. Injury	y at Work?		28d. Describe	•	•	
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Division of Vital Records, P.O. Box within 24 hours after death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the arte completely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director for the completely filled in by the funeral director for the completely filled in by the funeral director for the completely filled in by the funeral director for the completely filled in by the funeral director for the completely filled in by the funeral director for the completely filled in by the funeral director for the completely filled in the completely filled in the completely filled in the completely filled in the completely filled in the completely filled in the completely filled in the completely filled in the completely filled in the completely filled in the completely filled in the completely filled in the compl	Medical	(Check only certifying one) 2 Medical E	Physician: To the b examiner: On the basis and manner	s of exam			tion, in my	opinion,	death occ			e and pla	ce, and due to	the cause(s)
F > F 0	Ž	29b. Signature and title of cer	tifier			11	29c.		number					Month, Day, Year)
		11/1/				1/1		O.C.N	Л.E.			Nov	ember 16,	2011
d)		30. Name and address of pers Russell Alexander N			5		W Ralti	more	Street F	Baltim	ore, MD 2	1223		
Sta	ite	31. Pain filed Month Day Ye	1	Registra			, Dait				, , , , , , ,			
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Division of Vital Records, P.O.

Certificate: To Be Completed by Director: After filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical within 24 hou

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completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 21 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) owings mills, mD Crossroads Dr. suite 205 25 S. Lahn Joel 32. Registrar's Signature State Registrar ORIGINAL

			T = For State Registrar	State of M	aryland	•	artmen rtificat			and M		giene Reg. No. <sup>(</sup>	7111	1	37220
d	Physici	, an	1. Decedent's Name (First, Middle, La	•		·					2. Date of De Month	ath Day	Yes	ar	3. Time of Death
	/Medic		Vivian Elaine  4a. Facility Name (If not institution, giv	Hines	-1		45 Cib.	Town or	Location of	f Death	Month Novemb		County of D		6:00 P M
ſ	Examin	ier	Hospice of Queen		")		-		ville				)ueen		es
H	Funeral		5. Social Security Number 6. S	ex 7. /	lge (In yrs. I	ast birthday)		1 Year	If Under Hours		8. Date of Birt (Month, Da	v. Yeari		Birthpla Country	ce (State or Foreign
	Director		213-32-9778	□M 2ØF		77 Yrs.	Morning	cuyo	1.00.0		10/11,	/1934	!	Mar	ýland
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Location							10d. Inside City Limits			
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	ith the	Director	10e. Street and Number			-	10f. Zip	Code				10g. Citizen of What Country?			
	s 23a	rail	27 Robins Court	1 10 W 5	· · · · · · · · · · · · · · · · · · ·	0 40		.660		-:-2 (0-:		U.S.A.  14. Race - American Indian,			
	ter de	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceder Armed Forces 1 ☐ Yes 2 2	5?					gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	·   '	Black, V		
93	ral', o	þ	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	:		1 🗌 Yes	2 🛛 No	Specify:				Specify:	Whi	ite
2	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show the Mudical Exercities natal be notified at	Completed by Funeral	15. Decedent's E (Specify only highest gra			16a. Dece (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)			ing	16b. Kir	d of Busine	ess/Indu	stry	
121	within Bne. than	dmo	Elementary/Secondary (0-12)	College (1-4o	r 5+)		Homen						Ov	vn H	ome
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/lar	Menta Menta arked	To B	Amos Frances	Groff	ff Hazel					Bro	พท				
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination mail be notified at ance.		19a. Informant's Name/Relationship (											te, Zip C	Code)
e,	Health Health tem 2		David M. Hines /	Son	20b. PI	lace of Dispo	sition (Nai	ne of			Date		oution - City	or Tow	rn, State
Baltimore,	Pages ent of nt: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 🖫 Donation 5 ☐ Other (Special			amatary, crai natony				11/2	22/2011 Hanover, Marylar			yland	
alti	Departm Departm Importa eny Inju		21. Signature of Fural Service Licence 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 2											À	
	40 E # 9		1	1									nove		
			23a. Part1. Enter the disease or com- shock, or heart failure. List only Immediate Cause (Final									rrest,			Approximate Interval Between Onset and Death
ř.	Physician /Medical		disease or condition resulting in death)	a. end	is a consequ	uence of):	~~.»	+	a',   1	14				-	
*	Examiner	1.	Sequentially list conditions	b											
	sit ad	liner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to (or as a consequence of):											
	ate be executed hysician and the burial-transit	Examine	that initiated events resulting in death) Last	c. Due to (or a	is a consequ	uence of):								-	
68760	ysicia ysicia	call	(	d										4	
	antifica ing ph e as th	Med	IF FEMALE:												
Вох	death certifica e attending ph id for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcon 1☐Live birth 4☐Pregnant	2 Fetal	death 3	Ectopic p	regnancy				2	3d. Date of Month		y Day Year
o.	0 0 2	hysic	1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	9□ Unknown			_ C.i.o. (S)								
S, D	requires that the reen signed by th hould be detache	by P	Part II. Other significant conditions	contributing to death	but not resu	ulting in the u	inderlying o	ause give	en in Part I	*					cause of death?
Records	w require been si should b										10	Yes 2	<b>∑No</b> 3[	] Proba	bly 4 □Unknown
3ec	aw aw 2 s	Completed						-			24a. Was		24b. Wer prior dear	r to com	sy findings available pletion of cause of
lal	ilclan: The l certificate ha rector, page		25. Was case referred to medical				·		OC Plan	of Doot	1 Yes	2 100			2□ No
of Vital	Q w	To Be	examiner?	Hospital:	itient 2 🗌	ER/Outpatie	nt 3 D	Oth	or		me 5 ☐ Res		Other (	Specify)	Hospice
0 u			27. Manner of Death  ↑ Matural 5 ☐ Pending	28a. Date of In (Month, I	njury Day Year)	28b. Time o	f :	28c. Injun Worl			28d. Describe	how injur	y occurred		
sio	Attending r death. ector: Alter by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be		Injury At he		М		Yes 2 🗆	No	39f Location	Street 20	d Number	or Pum l	Route Number,
Division	or Attenated after deat Director:	Certification:	4 Homicide determined	28e. Place of building,	etc. (Specify	y)	reet, ractor	у, опісе			City or To			or riturar	riodie riumber,
	e Hospital or Atten 24 hours after deat Funeral Director: letely filled in by the	dicai C		hysician: To the be miner: On the basis	of examinat										
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner	sidieu.		29	c. Licens	e number				e signed (A		
	⊢ <b>≤</b> ⊢ ō	0			W.	0.5	2	200	53	32	5	11	18	/ə-	011
			30. Name and address of person who		f death (Item	23a) (Type	Print)			· O -	0		. ^		21622
	- CA	210		32. Regi	さんと strar's Si <b>en</b> a	ture •	no	4.	~~	4-6	722	340	~ V	ND	0/10/3
1	Regist	ate rar	31. Date filed (Month, Day, Year) NOV 2 2 2011	Centre	1	ture	d								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Nov 20, 2011 Physician/ Oliver Wilson Holloman 4:57 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Columbia Howard Gilchrist Hospice of Howard County Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. (Month, Day, Year) Oct 2, 1920 238-26-7371 91 NC Director 1 📈 M 2 🗆 F Usual Residence of Deced 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland notified at Director MD **Ellicott City** Howard 1 Yes 2 No 10e. Street and Number 10f. Zip Code ь 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be r Funeral 9938 Old Mill Rd. 21042 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 White If Yes, Give Year or Dates. WW II 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour IDepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natum injury or other traumatic event, the Medical any injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Retail Dept. Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Vance Holloman Norma 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Sheets 2629 Buckingham Rd. Ellicott City, MD 21043 son-in-law Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)
Crest Lawn Memorial Gardens Nov 23, 2011 Marriottsville, Maryland Qonation 5 COther (Specify 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 Hunliste MOD53, 23a/Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0 Physician/ COINC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death Month Day signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires i within 24 hours after death.

To the Funeral Director: After this certificate has been sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Division of Vital Records, Klanua Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy page Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Addical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check

Registrar

DHMH 17 Rev 06-2011

State

only one 29b. Signature and title of certif

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month. Dav. Year)

1-08687	Please Type or Print in Black Indelible Ink. Ensure All Copies Are L	egible.		
oan Barbara Harrison	State of Maryland / Department of Health and Mental Hygiene		2011	3722
1- For State Registrar	Certificate of Death	Reg. No.	2011	3122

	1- For State Registrar	Certificate	of Death	Reg. N	No. ZUII JIZZ							
Physician	Decedent's Name (First, Middle,Last)	<del> : - :</del>		Date of Death     Month Day Year 1125 hrs.								
Medical Examine	boail barbara nar			November 18	3, 2011							
	4a. Facility Name (if not institution, give str 2208 Creswell Road	et and number)	4b. City, Town, or Location of E Bel Air	eath:	4c. County of Death Harford							
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	·		/M/DD/YYYY) 9. Birthplace (State or Foreign							
Director	219-28-2624 1 M	2 <sup>X</sup> F 79	Yrs. Months Days Hours	Mar. 6,								
<b>A</b>	Usual Residence of Decedent	10c. City, Town or Lo			10d. Inside City Limits							
ow any	10a. State 10b. County				1 Yes 2 X No							
Maryland 28a-f show d at once.	Maryland Harford  10e. Street and Number	Bel Air	10f. Zip Code	100.0	Citizen of What Country?							
Eife b		l	21015	I -	SA							
er death with , or items 23 r must be no Funeral	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pa		14. Race - American Indian, Black, White, etc.							
er deat		Yes 2 X No	Yes 2 No specify:	,	Specify: White							
y, MD 21215-0036 and 2 should be filed within 72 hours after leath and Mental Hygiene. tem 27 is marked other than "natural", traumatic event, the Medical Examiner To Be Completed by 1	15. Decedent's Education (Specify only h	ghest grade completed) 16a. Dece	edent's Usual Occupation (Give kind		b. Kind of Business/Industry							
72 hor a "na al Ex	Elementary/Secondary (0-12)	College (1-4 or 5+)	g most of working life. DO NOT use	e retired)								
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	12	Home	emaker		Own Home							
Hygin the L	17. Father's Name (First, Middle, Last)  John Leonard Reynol	de		lame (First, Middle, Maidle) e (unk) Tro								
121( d be fill fental F fearked event, of	1		ailing Address (Street and Numbe		4							
MD 21 d 2 should th and Me n 27 is ma numatic ev	1											
and 2 and 2 lealth item 2 traun	Catherine J. Fletch 20a Method of Disposition	20b. Place of Dis	100 Jerrys Road, sposition (Name of cemetery,	Street, Ma-	CLocation - City or Town, State							
OFF ages l tr of l other	1 X Burial 2 Cremation 3 F	(eliloval il olil State	or other place)	1 22 2011 P	el Air, Maryland							
Baltimore, permit. Pages I an Department of Hee important: If iten injury or other fr	4 Donation 5 Other Specify: 2 is a fure of Funeral Service Licensee	Mt. Zioi	2. Name and Address of Facility	McComas Fu	nera Home, P.A.							
Dem Dem Initial	11/1/1/20 11	1317 Cokesbury Road, Abingdon, Ma										
Physician	3a. Part I. Enter the disease, or conflict failure. List only one cause of a life	ns that caused the death. Do not en	ter the mode of dying, such as card	iac or respiratory arrest,	shock, or heart Approximate Interval Between Onset and							
/Medical £xaminer	Immediate Cause (Final disease a. Hea	nd Injuries with complications	3		Death							
	or condition resulting in death)	to (or as a consequence of):										
4	Sequentially list conditions, bbb	to (or as a consequence of):										
	cause. Enter Underlying Cause (Disease or injury that initiated											
ecuted and and transit	events resulting in death) Last Due	to (or as a consequence of):										
S E =   .9	UNPENDED	MENDED		=								
1760, ficate be exe sphysician a the burial -	IF FEMALE: 2	3c. If yes, outcome of pregnancy			23d. Date of delivery							
		Live birth 2	Fetal death 3 Ectopic pr	egnancy	Month Day Year							
D. Box 687 t the death certifi by the attending ached for use as I Physician	1 Yes 2 ✓ No 9 Unknown 9	Pregnant at time of death 5	Other (Specify)									
O. B. It the d by the by the ached	Part II. Other significant conditions con	tributing to death but not resulting in t	he underlying cause given in Part I	. 23e. Did tobaco	co use contribute to the cause of death?							
res tha signed be det	History of falls, DVT's Pulmo	nary Embolism, Carotid Ster	nosis, C-Diff, Popliteal vein	1 Yes 2	Probably 4 ✔ Unknown							
of Vital Records, P.O. ng Physician: The law requires that the this certificate has been signed by meral director, page 2 should be detacen: To Be Completed by F.	thrombosis			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of							
e law te has ge 2 sl			<del></del>	performed	d? death?							
Vital Rec ysician: The his certificate director, page	25. Was case referred to medical		26.Place of Death (Ch		7,00							
f Vital Physician: Tribis certificated director To Be	examiner?  1 Yes 2 No	tal: 1 Inpatient 2 ER/Outpat	ient 3 DOA Other N	ursing Home 5 Res	sidence 6 🗸 Other: Scene							
ding Ph After t funeral	27. Wathrel of Death	28a. Date of Injury 28b. Time FOUND: FOUND: FOUND:		28d. Describe how	injury occurred ned probable fall							
trendi death. tor: the f	1 Natural 5 Pending 2 Accident Investigation	Nov 4, 2011 0000 hrs	1 163 2 7 10	Subject Sustain	ica probabie iaii							
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as redical Certification: To Be Completed by Physician	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s (Specify) Single Family Home		28f. Location (Stree or Town, State) 2208 Creswell Ro	et and Number or Rural Route Number, City )							
Lospital of thours a functional light filled	4 Homicide  29a. Certifier 1 Certifying Physician:	To the best of my knowledge, death or										
To the How within 24 h To the Fur completely	(Check only one) 2 Medical Examiner: On	the basis of examination and/or invest manner stated.										
	29b. Signature and title of certifier	manner stated.	29c. License number		d. Date signed (Month, Day, Year)							
	TO. 10. 11 T	Cal Ta	O.C.M.E.	ICME N	ovember 19, 2011							
	30. Name and address of person who comp											
	Theodore M. King, Jr., MD.	Assistant Medical Examiner		t, Baltimore, MD 21	1223							
State Registra	BILLIO V Z Z	32. Registrar's Signature	park									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 17, 2011 2:13 A M Lov Brannon Heare Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Rock Spring Village Assisted Living Harford Forest Hill 8. Date of Birth (Month, Day, Year) Feb. 15, If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Hours 1 X M 2 🗆 West Virginia Director 188-20-4182 85 Feb. 1926 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Maryland| Harford Joppa ò 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 1606 Old Joppa Road 21085 USA items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 6 à 1 Never Married 2 Married 1 X Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ₩ Widowed 4 □ Divorced Specify: "natural" White Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Machineist Steel Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Newton Heare Ella May Shank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 168 Arthur Ave., Port Deposit, Maryland 21904 Page 1 and 2 Donna M. Vest / Daughter Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Flat Rock Cemetery 11-21-2011 Independence, VA Synature of Funeral Service Li 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a con-quent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin ettending physician and or use as the burial-transit Physician: The law requires that the death certificate be executed Cause (Disease or illinury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions con ributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate | within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending 1 Natural iniury work? 1 ☐ Yes 2 ☐ No [Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce tific 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Physicia Medic	al	For State Registrar  1. Decedent's Name	illa	M Ha	//	Cei	tificate of		2.	Date of Dea Month	Day	Year 2011	3. Time of Death
Examin	CI	64LTIMO	RE WASH	e street and number) HINGTON M Sex 7. Age 1 $\square$ M 2 $\boxed{\mathbf{X}}$	e (In yrs. la	st birthday)	4b. City, Town, of the City, Tow	B41	er 24 Hrs. 8.	Date of Birth	1	ne A	lace (State or Foreign
Director k st at second	tor	Usual Residence of 10a. State	Decedent 10b. County		<b>56</b> 10c. City	Yrs. Town or Lo				April 1	5, 1955		0d. Inside City Limits
vith the Man 23a or 28a- st be notifie	eral Director	MD 10e. Street and Nurr 8201 Parha		del	Seve	10f. Zip Code 21144					1 ☐ Yes 2\(\overline{\chi}\) N  10g. Citizen of What Country?  USA		
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	11. Marital Status  1  Never Marri 3  Widowed	ed 2 MMarried	12. Was Decedent E Armed Forces? 1  Yes 2 If Yes, Give Year or Dates.	ver in U.S No	- 1		Hispanic C an, Mexic		uerto Rican, etc.)		Race - American Indian, Black, White, etc.  Specify:  Black	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Examples.	Completed	(Spec	15. Decedent's I cify only highest g onday (0-12)	Education rade completed) College (1-4 or 5	+)	(Give	dent's Usual Occup kind of work done O NOT use retired,	during me	ost of working	ı	16b. Kind of E		•
Maryland 2 12 should be filed w 11 should be filed w 12 is marked other r traumatic event, i	To Be	17. Father's Name (F  Eddie Will: 19a. Informant's Na	s Sr.			10h Maili	ng Address (Street	Ma	other's Name (Fire Cager				tada)
ore, Ma le 1 and 2 sho t of Health an If item 27 is or other trau		George Hal	1. Sr.	X Removal from State	CE	8201 ace of Dispo	Parham Ct., sition (Name of matory or other pla	Seve	rn, MD 21	1144	20c. Location	- City or To	wn, State
Baltimo permit. Page Department c Important: If any injury or		4 ☐ Donation  21. Signature of Fun	5 Other (Spec	ify)			Cemetery  Name and Addre  426 Crair	ess of Fac	Nov 23, 2 S., Glen	-	Hopkins , MD 210		кү
Pry ician Medical		23a. Part Enter the shock, or hear Immediate Cause (fidisease or condition resulting in death)	Final	nplications that caused one cause on each line  a.  Due to (or as a	ō	Lun	er the mode of dyin			spiratory arre	est,		Approximate Interval Between Onset and Death
icate be executed by physician and maisten stransit stre burial-transit	edical Examiner	Sequentially list cor if any, leading to im cause (Disease or i that initiated events resulting in death) L	mediate tying injury	b. Due to (or as a Due to (or as a d.									
Box 68' death certifi he attending ed for use as	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 9 ☐ Unknown	ponths?	23c. If yes, outcome of Live Birth 4 Pregnant at 9 Unknown	2 🗀 Fetal	death 3	Ectopic pregnan Other (specify)	юсу				ate of delive onth	ery Day Year
Division of Vital Records, P.O. Box 68° for the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	leted by Ph	Part II. Other signifi	. / -	ns contributing to death but not resulting in the underlying cause given in Part I.  Hyper coagy/gb//rty					art I.	23e. Did tobacco use contribute to the cause of d			
of Vital Reco Physician: The law r this certificate has k tral director, page 2 s	Be	25. Was case referre examiner?		Hospital:					eath (Check onl	24a. Was a autop: perfor 1 Yes y one)	sv	prior to cor death? 1  Yes	psy findings available inpletion of cause of 2 No
ion of Vironding Physicath.  tor: After this countries the funeral din	Certificate: To	1 Yes 2 2  27. Manner of Death  1 Natural 2 Accident 3 Suicide		1 ☐ Inpatie 28a. Date of injur (Month, Day	y ; Year)	28b. Time of injury	M 1 🗆	4 <u>∟</u> ryat	□No	Describe ho	w injury occur	red	
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Stat	te	30. Name and addre	ess of person who $Q$	completed cause of de	eath (Item	23		150	ital C	), 1,16	Glen	Busni	e, Md-21061
DHMH 17 Rev 7/20	ar	1401	~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	- Charles	<i>y</i> .	7-3	****				9,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 1 37225 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death No vember Physician/ Joseph E. Hamilton 10:15 pm M 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner Harbor Hosp: fa Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Jan 17, 1932 1 X M 2 D F Mary Land 213-32-8096 77 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits ms 23a or 28a-f sho must be notified at 10a. State 10h County 10c City Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Baltimore N/A Maryland 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 600 Light St., Apt. #735 USA Funeral 21230 an "natural", or items Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 X Married Completed by Saltimore, Maryland 21215-0036 White 1 ☐ Yes 2 A No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Whitman-Requardt Engineering the Building Management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Hamilton Thelma Fout မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra-(Wife) Emma K. Hamilton 600 Light St., Apt. #735, Baltimore, Maryland 21230 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 X Burial 2 Cremation 3 Removal from State 11/21/2011 Baltimore, Maryland Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fural Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 130 E. Fort Ave., Baltimore, Maryland 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Severe obstructive disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Year Month Day Yes 2 No 9 Unknown 9 Unknown as been signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? has To the Hospital or Attending Physician: The la within 24 hours after death.

To the Funeral Director: After this certificate ha completed filled in by the funeral director, page Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 5 Pending 1 Matural 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioners To the best of the knowledge, death on 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar South

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3091

RESOOI

a) (Type, Print) Hanouer Street, Baltimore, MD 21225

November, 16, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2:32PM Physician/ Month Day Louis Haynie, Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomico If Under 9. Birthplace (State or Foreign Funeral 8. Date of Birth 1 ■ M 2 □ F Months (Month, Day, Year) June 26, 1932 Maryland Hours 215-28-9693 Director 79 June Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location at 10d. Inside City Limits Director or 28a-f st notified 1 Yes 2 X No Maryland Worcester Berlin 10e. Street and Number 10f. Zip Code ed other than "natural", or items 23a or event, the Medical Examiner must be n 10g. Citizen of What Country? Funeral 19 Rockside Road 21811 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 X Married Yes 1950-2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify. 3 Widowed 4 Divorced Specify: Completed 1951 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Gas Engineer Constellation Energy To Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Louis Ε. Haynie, Sr Margaret Barry Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health are Important; If item 27 is any injury or other trau Dorothy E. Haynie (Wife) 19 Rockside Road Berlin Maryland 21811 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore National Cem 11/28/2011 Baltimore, 21. Signature of Fu eral Service Licensee 22 Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 any ir 23a. Part . Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ EM disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) l by the attending physician and etached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of the Hospital or Attending Physician; The law has autopsy perform death? Yes Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) of 27. Mannu f Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending Division 1 Yes 2 No Accident Investigation Suicide
Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day, Year) d cause of death (Item 23a) (Type, Print) TEKN STORE DK, SALISBURY MD21804 2 State Registrar

DHMH 17 Rev 7/2009

11-08695 Charles Henly

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Phys Medical Exa		n/	Decedent's Name (First, Middle,Last)			2. Date of Dea	ath Day Year	3. Time of Death						
Madical Exa	MIIIA		Charles Lawrence Henly  4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of		er 18, 2011 4c. County of Deal							
			Good Samaritan Hospital		Baltimore	, Doddi	N/A							
Fune			5. Social Security Number 6. Sex 7. Age (In y	rs. last birt	nday) If Under 1 Year If Under Months Days Hours	Min	irth(MM/DD/YYYY) 9. Bi Forei							
Direct	Or	L	220-25-1849   1 xm 2 F	22	Yrs.	11/07		ountry) MD						
any		- 1	Usual Residence of Decedent  10a. State 10b. County 10c. (	City, Town	or Location			10d. Inside City Limits						
and show	at once.	5	MD N/A		Baltimore			1 XYes 2 No						
Maryl	ed at o	Tect	10e. Street and Number 6120		10f. Zip Code		10g. Citizen of What Cou	•						
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f she	notified	=	6321 Chinquapin Pkwy 11. Marital Status 12. Was Decedent Ever	in U.S	21239  13. Was Decedent of Hispanic Orig	in? ( Specify Ves or N	U.S.A.	rican Indian, Black,						
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	the Medical Examin	Completed	1 year		Student		N/A							
e, MD 21215-003. I and 2 should be filed within Health and Mental Hygene. item 27 is marked other th			17. Father's Name (First, Middle, Last) Terence Terrance Henly		18.Mother:	s Name (First, Middle,	Maiden Surname) die de Luri	oe						
212 vuld be Menta mark	c even	0	9a. Informant's Name/Relationship (Type, Print )	19b	. Mailing Address (Street and Num									
MD d 2 sho lth and	in a		Terence Terrance Henly(father)	80	1 Unetta Ave.									
= s 5 =	2		20a. Method of Disposition  1 ** Burial 2 Cremation 3 Removal from State		f Disposition (Name of cemetery, ary or other place)	Date	20c. Location - City or	Town, State						
Baltimore, permit. Pages 1 a Department of He Important: If ite	y or of		t Delianer of Outer opening.	AD Na		11/26/11	Laurel,							
Bal permi Depar		1	21. Signature of Funeral Service Licensee  22 Name and Address of Facility  23 Name and Address of Facility  30 Sephi H. Brown Jr. Funeral Home  2140 N. Fulton Ave., Baltimore,											
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Vita hysicia this ce	al directo	o۱	examiner?  1 ✓ Yes 2 No Hospital: 1 Inpatient 2	<b>✓</b> ER/Ou	IOthor -	Nursing Home 5	Residence 6 Other	:						
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending physician and			9a. Certifier 1 Certifying Physician: To the best of my know ne) 2 Medical Examiner: On the basis of examinatio											
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	-		The de Million -		O.C.M.E.	OCME	November 19, 20							
		3	O. Name and address of person who completed cause of death (it		w0,1									
	C/4	2	Theodore M. King, Jr., MD. Assistant Medica  1. Date filed (Month, Day, Year)  2. Registrar's Sign		ner 900 W. Baltimore Stre	et, Baltimore, MD	21223							
Reg	State istra	~	NOV 2 2 2011	Tur o	suled									

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Janice Marie Hemling		Stat
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	1- For State Registrar		cate of Death		Reg. No.							
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,La Janis Marie Heml	ing			er 18, 2011 1756 hrs							
	4a. Facility Name (if not institution, gi 11345 Pulaski Highway #	47	4b. City, Town, or White Marsl	1	4c. County of Death Baltimore County							
Funeral Director	5. Social Security Number 6. S 214-82-5396 1	Fig. 1. Age (In yrs. last b	irthday) If Under 1 Year Months Days Yrs.	Hours Min. July	irth (MM/DD/YYYY) 9. Birthplace (State or 24, 1959 Foreign Country) VA							
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ith the Maryland 23a nr 28a-f sho notified at once. al Director	10e. Street and Number 1118 Bush Rd.		10f. Zip Code 21009		10g. Citizen of What Country? USA							
ter death wi , nr items er must be Funera		1 Yes 2 X No d If Yes, Give Year or Dates:	If Yes, specify Cuban		White, etc. specify.White							
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Baltimore, M bernit. Pages I and 2 Department of Health Important: If item 2 injury nr other traur	20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other Specif	Removal from State R.A.	e of Disposition (Name of cer latory or other place) Ferris & Co.	. 11/22/2011 West Chester, Pennsylvania								
Baltimo permit. Page Department c Important: injury nr ott	Signume of Functions and Address of Facility  Tarring-Cargo Funeral Home, P.A.  333 S. Parke St. Aberdeen, MD 21001  Approximate Interior the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Polymen Open.											
Physician Medical Examiner	234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Mixed drug(methadone and diazepam) and alcohol  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Approximate In Between Onse Death  Due to (or as a consequence of):											
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ox 687 eath certifi attending for use as f	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 ✔ Unknow	1 Live birth 4 Pregnant at time of death	2 Fetal death 3 5 Other (Specify)	Ectopic pregnancy	. Month Day Year							
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detactly entification: To Be Completed by Pertification: To Be	27. Manner of Death  1 Natural 5 Pending  2 X Accident Investiga	tion fd 11-18-11 f	d 06:00 pm unki	es 2 No subjection No alcohol								
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To the Hospital within 24 hours To the Runeral completely filled												
Ž Ž	29b. Signature and title of certifier		number	29d. Date signed (Month, Day, Year)  November 19, 2011								
	30 Martie and address of person who	o completed cause of death (frem 23a	O.C.1	VI. L.	14046HDG1 13, 2011							
	Russell Alexander MD	Assistant Medical Examine		Street, Baltimore, MD 2	1223							
State Registrar	31. Date filed (Month, Day, Year) NOV 2 2 20	32. Fegistrar's Signature	barked									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death edent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death INGRAM Month Physician/ 5:36 Medical Name (if not institution, give street and City, Town, or cation of Death 4c. Countwof Death **Examiner**  Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months Hours Min. (Month, Day, Year) 214 50 7690 Director 1 X M 2 🗆 F 69 10/23/1942 Marvland ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 5th Street 21225 Funeral 3915 death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🅱 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. <u>-</u> þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: White 27 is marked other than "natural", traumatic event, the Medical Exar Specify: 3 Widowed 4 Nivorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Bob's Salvage Self Employed Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) n and Mental Fis marked o ည John R. Ingram Jr. Anna B. Matulitis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Ingram /sister item 27 3915 - 5th Street Baltimore, Maryland 21225 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important of any injury or 1 X Burial 2 Cremation 3 Removal from State 11/22/2011 Cedar Hill Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22, Name and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway 23a Part 1. Enter the dispase, or complications it at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Interval Between Onset and Death Immediate Cause (Final Physician/ teriose disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence on. attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be after death. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death sate has been signed by the a page 2 should be detached Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 2 1 Tyes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 Yes 2 No 1 Yes 2 🖳 the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes Hospital Other: 2 No မ 1 Inpatient 2 FR/Outpatient \_3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: Natural Accident 5 Pending Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier one 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Pearl Roslyn Johnston **11:1**5а м Nov 18 2011 Medical 4a. Facility Name (if not institution, give street and number)
Stella Maris Hospice 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Baltimore . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 219-05-6985  $95_{\,\mathrm{Yrs}}$ July 20, 1916 Country 1 □ M 2 □¥ Director Usual Residence of De Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Funeral Director MD Baltimore or 28a-f Essex 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 516 Dorsey Avenue 21221 USA "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc Completed by 1 Never Married 2 Married ☐ Yes 2 🕅 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) and Mental Hygiene, is marked other tha Meat Inspector Esskay Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Frank Wiegand Anna Geis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Johnston / son item 27 28 Hurst Road Wilmington DE 19803 injury or other 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If it
any injury or ot
once. HoTery refir111 cometery 11/22/ 1 XXrial 2 Cremation 3 Removal from State 1 Baltimore MD 4 Donation 5 Other (Specify) 21. Signature of Tun 1 Ser 22. Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or comply shock, or heart failure. List only or cations that caused the cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ EBROVASC disease or condition Medical resulting in death) or as a consequence of) Examiner Sequentially list conditions, if any least sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to jor as a consequence of attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 9 Unknown g Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🔲 Yes Yes 2 Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence Division of V After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 29a. Certifier within 24 hor To the Fune completely fi Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature an 29c. License number 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) RNP 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Robert K. Johnson, Jr. Nov. 15 2011 3:10 p. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Center Baltimore Towson Birthplace (State or Foreign Country) If Under 24 Hrs. . Age (In yrs. last birthday) 8 Date of Birth Funeral Hours Min (Month, Day, Year) 1 M 2 D F Director 213-68-7546 Usual Residence of Decedent 56 Apr. 10,1955 Maryland 28a-f shov items 23a or 28a-f shorer items to be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Sparrows Point Maryland 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 4429 Todd Point Lane 21219 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Black, White, etc. o p 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 nan "natural", o 1 Yes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working nd Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) event, the 12 Years Officer Correctional Corrections Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I is marked o ည Viola DeBaufre Robert K. Johnson Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Sheri Johnson 4429 Todd Point Lane Sparrows Point, MD 21219 (Wife) 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o ŏ cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 🖺 Donatio Tother (Specify) Entombrent Holly Hill Cemetery Nov. 19,2011 Middle River 21. Signal 22. Name and Address of Facility ieral Ser Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave Dundalk, Maryland 21222

The death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 

Approximate 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each, Interval Between Onset and Death Immediate Cause (Final Physician/ OSTATE cance disease or condition resulting in death) Medical to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury and that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician at the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death the 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe Yes 2 certificate | 1 Yes 2 No 1 Yes To the Hospital or Attending Physician; filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) WINGU ည 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number

State Registrar 32. Registrar's Signature

M.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARCKI

Chances ST TONS ON MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 15 Melissa Gwendolyn Jackson Nov 2011 0600 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Gilchrist Hospice Baltimore Towson If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours Min 217-24-3730 Director 1 M 2 F Maryland 83 Yrs. June 6, 1928 Usual Residence of Decede show 10d. Inside City Limits 10h County 10a. State 10c. City, Town or Location at by Funeral Director must be notified N/A Baltimore 1 Yes 2 No - 28a-f MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 5 2542 Druid Park Drive 23a 21215 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death Was Decedent Eyer in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 14. Race - American Indian 11. Marital Status Black, White, etc. 1 W Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than mentary/Secondary (0-12) 8th Grade College (1-4 or 5+) Miller Brothers Restaurant Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Regina Johnson Leroy Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Jeanette Jackson – Daughter 2542 Druid Park Drive Baltimore, Maryland 21215 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 M Burial 2 Cremation 3 Removal from State Mt. Zion Cemetery 11/21/2011 Lansdowne, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman—Harris Funeral Home wer 5240 Reisterstown Road Baltimore, MD. 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a Jonsequence **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Dus to for as a consequence of: Cause (Disease or injury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 Who Month Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 XNo Other: 4 Nursing Home 5 Residence 6 Nother (Spe မ 1 Inpatient 2 ER/Outpatient 3 DOA After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending in 24 hours after death.
The Funeral Director: Aft 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

CMMUE!

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Regina Jones 203 Medical jovemb 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) MCICA 20 7. Age (In vrs. last birthday) Funeral 9. Birthplace (State or Foreign Country) Days Hours Min. 216-44-6132 Director Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits be notified 28a-f MD N/A 1 Yes 2 No Baltimore 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral must 1315 Pentwood Ave. 21239 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item Z7 is marked other than "natural", or items; any injury or other traumatic event; the Medical Examiner mu once. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. 1 X Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) 10th N/A Disabled N/A Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unkwn ည Frances Jones Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cherlyn L. Janes— Daughter 1315 Pentwood Ave. Baltimore, MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Trinity Cemetery 11/22/2011 Baltimore, MD 21. Signature of Funeral Service Licensee

Bramlon McRun 22. Name and Address of Facility March F/H 1101 E. North Ave. Baltimore, MD. 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death Coronary disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami nding physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cesebro vas cular Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Seizure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe Hypertension this certificate 1 ☐ Yes 2 📉 No Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No 2 Accident
3 Suicide 24 hours after deat Funeral Director: Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined 28f. Location (Street and Number or Rural Route Number. 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or inve 3 Certifyin: Nurse Practioner: To the best of my in ... Wild 3 within 2 only one 29b. Signature and title of certifier D 34851 November 18, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert 7 560 / Loch Raven Blvd Baltimore, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

NOV 2 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death Physician/ NOV. 2011 11:40 P M 1<sup>2</sup>3<sup>y</sup>, ODELL JACKSON Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE TIMONIUM STELLA MARIS 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min **Director** 75 241-50-7870 1 XM 2 □ F Yrs 2/19/1936 NC Usual Residence of Deceden 28a-f shov 10b. County items 23a or 28a-f shoner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director WHITE MARSH MD BALTIMORE 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 11152 PHILADELPHIA RD 21162 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, than "natural", or iter he Medical Examiner Black, White, etc. ģ 1 Never Married 2 X Married 1 Yes 2 No Specify. Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the TRUCK DRIVER YELLOW FREIGHT 10 and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည THELMA .NORRIS THADDIUS JACKSON 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health an. Important: If item 27 is n. any injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $11152\ PHILADELPHIA\ RD\ WHITE\ MARSH,\ MD\ 21162$ BERLINE JACKSON-WIFE 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH BALTIMORE, MD 11/22/11 Signature of Funeral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME NOTTINGHAM, MD 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) NEWN Medical Due to or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Examir Cause (Disease or injury physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 12をLLJ ACKS m Division of Vital Records, P.O. Box 68760 as IF FEMALE: Se 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death the Unknown 9 Unknown as been signed by 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has page 2 🗆 No 1 Yes Yes Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 Hospital Other: 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 Pending Natural 1 Tyes 2 🗌 No Accident within 24 hours after death

To the Funeral Director: / Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gentrying Nurse Fractitioner: To the best of my knowledge, Seath occurred at the time, date and place, and due to the name(s) and manner as state 29b. Signature and t 29c. License number who completed cause of death (Item 23a) (Type, Print) 30. Name and 0 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Cer	rtificate of	Death			R	leg. No.		
Physic	an/	Decedent's Name (First, Mide	dle,Last)						2. Date of Dea	ath	3. Time of Death	
Medical Exam		Bethany	imenez						Month Novembe	Day Year er 15, 2011	1429 hrs	
A. A.		4a. Facility Name (if not instituti	on, give street and nu	mber)		4b. City, Town,	or Location	of Death		4c. County of	f Death	$\exists$
		6222 Iron Wood Way	<i>'</i>			Columbia	1			Howard		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Y	ear If Unde	er 24Hrs.	8. Date of Bi	rth(MM/DD/YYYY)	9. Birthplace (State or	ᅱ
Director		217-21-0684	1 M 2XXF	33	V		ays Hours	Min.	3/27/1978 Foreign Country) MD			
			1 M 24528F		Yrs				3/2/	11570	Country) PID	$\dashv$
any		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Locati	ion					10d. Inside City Limit	-
<b>.</b>		,									1 Yes 2 XXV	- 1
Aaryland 28a-f show 1 at once.	ō	MD Howa	ırd	Col	Lumbia							<u> </u>
Mary 28a-	Director	10e. Street and Number				10f. Zip Code	9		1	10g. Citizen of Wha	at Country?	
ith the Maryland 23a or 28a-f sho notified at once.		6222 Ironwood	l Way			21045				USA		
with <b>23</b>	Funeral	11. Marital Status		edent Ever in U.	U.S. 13. Was Decedent of Hispanic Origin? ( Spe				cify Yes or No	o- 14. Race -	- American Indian, Black,	⊣
r death wi or items must be	une	1 Never Married 2XX N	Married Armed Fo	orces?	lf Y	es, specify Cut	oan, Mexican	, Puerto F	Rican, etc.)	White,	etc.	- 1
terd		3 Widowed 4 Di	vorced If Yes, Give Yea	L ZVV MO	1	Yes 2XX No specify: ent's Usual Occupation (Give kind of work done				Specify: V	White	
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	d by	15. Decedent's Education (Sp	or Dates:		16a. Deceden				ork done	16b. Kind of Bus		ᅱ
2 hou	Completed	Elementary/Secondary (0-12	) College (1	-4 or 5+)	during me	ost of working	life. DO NOT	use retire	ed)			
36 thin 72 than than edical	힞		4				anning			Aquat	tics	- 1
-00- l with	OIL	17. Father's Name (First, Middle	a Last)			-			First Middle	Maiden Surname)		
The Bar	Be C	Mark Fowler	,,				1		Cumbe	<i>'</i>		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	To B	19a. Informant's Name/Relation	ship (Type Print)		19h Mailing	Address (St				mber, City or Town	State Zin Code)	
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Montal Hygien feeth and Montal Hygien feeth and Wasternally, or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	E									MD 20724		- 1
and 2		Mrs. Deborah S	maw / Moti		Place of Disposi			.11 Т	Date		t City or Town, State	$\dashv$
of He		1 XXBurial 2 Crematic	n 3 Removal fr		crematory or oth		ociniotory,		Date	Zoc, Location - C	ony or rown, onate	
Pages 1 and of Hunder of H		4 Donation 5 Other S	Specify:	Mea	dowridg	ge Mem.	Park	11/	21/11	Elkridg	ge, MD 21075	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within permit. Pages I and 2 should be filed within Important: If item 27 is marked other the injury or other traumatic event, the Med		21. Signature of Funeral Service		<u> </u>	22. N	ame and Addr	ess of Facility	Sing	leton	Funeral 8	Cremation	٦
E L D B M		NIX	_ Ne	1220							rnie, MD 21061	$1 \mid$
Physician		23a. Part I. Enter the disease of failure. List only one cause	r complications that c	aused the death.	Do not enter th	ne mode of dyir	ng, such as c	ardiac or	respiratory arr	rest, shock, or hear	rt Approximate Interva	
/Medical		Immediate Cause (Final disease	Promoth	sed drug	nd Omet	ianine`	Tntov	icat:	ion	me,	Death	1
Examiner		Immediate Cause (Final disease or condition resulting in death)  a Promethazine and Quetiapine) Intoxication  Death  Due to (or as a consequence of):										$\dashv$
	Sequentially list conditions, b											
	ē	if any, leading to immediate		consequence of	0.							$\neg$
^	盲	cause. Enter Underlying Cause (Disease or injury that initiated	c									
The R	Examiner	events resulting in death) Last	Due to (or as a	consequence of	i):							
760, (cate be executed physician and the burial - transit			¬ d	222 27 2	00 F 5		022 12	2 1	1			$\dashv$
O, e be execut vsician and burial - tra	/Medical	X UNPENDED		23a,27,2		er me, g	,922 12	.–2–1	1 8111			
		IF FEMALE: 23b. Was decedent pregnant in t		outcome of pregr	· —					23d. Date of d		
68 Certif	ä	past 12 months?	1 Live b	irth ant at time of de			3 Ectopio	c pregnan	су	Month	Day Year	
Box 687; death certifi.	/sic	1 Yes 2 No 9 🗸 Ur			atri 5 Oth	ner (Specify)						
the de	Physician	Part ii. Other significant condi			sulting in the u	nderlying caus	e given in Pa	art I	23e. Did to	obacco use contrib	oute to the cause of death?	$\dashv$
Records, P.O. The law requires that the licate has been signed by the page 2 should be detached.	ã	•	g			.,,	- g, -		1 _		Probably 4 V Unknown	
puires												_
cords law requi	ple	1							24a. Was autor	osy pri	ere autopsy findings available for to completion of cause of	
Reco	Completed								perfo 1 ✓ Yes		eath? ✓ Yes 2 No	١
tal Recision: The certificate		25. Was case referred to medical	al			26.Pla	ace of Death	(Check or	nly one)		<u> </u>	$\dashv$
Vital  hysician: this certil	Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	npatient 2	ER/Outpatient	3 DOA	Other <sub>4</sub>	Nursing	Home 5	Residence 6	Other: Scene	٦
of \ ing Phy After th	. To	1 Yes 2 No 27. Manner of Death	28a. Date		28b. Time of Ir	njury 28c. Ir	njury at Work	? 2		how injury occurred		ᅱ
ading th.: Af	Ö	1 Natural 5 Pen		Day, Year) 1-15-11	fd 02:2	0 pm 1	Yes 2 X	No S	ubject	ingeste	d medications	;
Sic Atter r dear ector by th	cat	2 Accident Inve	stigation	e of Injury - At ho		-	e building et	<u> </u>	98f Location (	Street and Number	or Rural Route Number, City	$\mathcal{H}$
Division pital or Attendio ours after death. teral Director: A	Certification:	dete	ild flot be	Res	idence	it, ractory, onto	c ballaling, or	ı	or Town, S	State 6222 In	ron Wood Way	1
1 6 8 P										$\dashv$		
n 24 n 24 ne Fu	ca	To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Contributing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									-1	
To the Hos within 24 h To the Fun completely	Medical		and manner s		aroi investigati			San et al	ano umo, uate			$\dashv$
	Σ	29b. Signature and title of certifi	er	1	6		ense number				(Month, Day, Year)	
2		1/2	0	16-	164	) 0.0	C.M.E.			November 1	6, 2011	
(11)		30. Name and address of person	who completed caus	e of death (Item	23a)				-	<u> </u>	-	$\dashv$
Oxogo		Russell Alexander MI			A	W. Baltimo	re Street,	Baltimo	re, MD 21	223		
S	tate	31. Med Med Stoken, 20 Var	Change Re	gistar's Signal	the				***			$\dashv$
Regis			4									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day KROEMIN INDIT 55 A 9 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Good Samaritan Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Caphtry) Ball Limore Mary Land . Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🔀 F Months Days Hours August 11 61 215-58-4309 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 21221 U.S.A. 201 Antietam Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: White 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Clerk 12 permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Clark Clara Belle Lunckin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Antietam Road, Baltimore, Maryland 21221 Mrs. Jean Dritt (Sister) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Dularey Valitey Whiteral November 22, 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland Gardens 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services — Bel Air
3 Newport Drive, Forest Hill, Maryland 21050 21. Signature of Julieral Service Licensee Jeffrey R. Testerman any in (M01543)23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause (Final disease or condition

A SC

C Approximate Interval Between Onset and Death Ph\_ician/ Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or iii ijury Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death ☐ Pregnant ☐ Unknown been signed by the should be detached to g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy this certificate Yes 2 funeral director, Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ဥ 1 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After injury 1- Natural 5 - Pending death. Accident Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 00 21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHA SHID HARAN 31. Date filed (Month, Day, Year) NOV 2 2 2011 32. Registrar's Signature filate

DHMH 17 Flav 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 00:17AM Physician/ Knighton Elizabeth Gloria 201 Verember Medical Facility Name (if not institution, give street and num 4c. County of Death City, Town, or Location of Death Examiner Sinai Hospital 0/ Baltimose Baltimare If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) 241-54-4262 Usual Residence of Decedent 75 Director 1 □ M 2**X** F 36 NC 13 07 10d. Inside City Limits at 10a. State 10b. County 10c. City, Town or Location with the Maryland Director Pikesville must be notified 28a-f MD Baltimore 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō 21208 U.S.A. 23a Funeral B227 Brattle Road items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc or δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🔀 No Specify: "natural" Completed 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working nd Mental Hygiene, marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sales Sears na Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Kernal Walter Faribault 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8227 Brattle Road, Pikesville, Md 21208 19a. Informant's Name/Relationship (Type, Print) Roland Knighton-Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date cemetery, crematory or other place) 12/1/2011 Owings Mills, Md Donation 5 D Other (Specify) Garrison Forest 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, 21. Sign sture f Funeral Service Licensee Baltimore, 21215 23a. Part I. Enter the disease, or complications that calcshook, or heart fallule. List only one cause on each Approximate Interval Between Onset and Death ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ aute Due to (or as a consequence of) disease or condition Medical resulting in death) Examiner cequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): the burial-transit and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year been signed by the a should be detached f 1 Yes 2 9 Unknown Yes 2 No Part IL Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform ours after death.

eral Director: After this certificate I filled in by the funeral director, page Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 Yes မ 1 Inpatient 2 -ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at work? 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my in order as at the firm of the cause and due to the cause and due t 29a. Certifier (Check Cartifying Nurse Practitioner: To the best of my knowledge 29b. Signature and title of certifier 29c. License number Tinci Hospital of Ralbinise 31. Date filed (Month, Day, Year) 32. Registrar's S natur State NOV 2 2 201 Registrar

M DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37238 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Margaret Aleathia Klinefelter 19 2011 <u>6:51pm</u> <sup>M</sup> Nov Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Dove House Westminster Carroll 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Days Min. Hours **Director** 212-32-0720 1 □ M 2🏋 F 92 11-24-1918 MD Usual Residence of Deced 28a-f shov 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location Director 10d. Inside City Limits MD 1 ☐ Yes 2X No Baltimore Reisterstown 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? pe Funeral er than "natural", or items 23a the Medical Examiner must b 13208 Old Hanover Road 21136 United States permit. Page 1 and 2 should be filed within 72 hours after death bepartment of Health and Mental Hygiene.
Important: I ferm 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. Completed 3X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Towson State 12 years Laundry worker University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph P. Riley Mary V. Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert M. Klinefelter Son 1106 Canterbury Ct. Gamber, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem. Gardens 11/23/11 Finksburg, MD Signature of Funeral Service License 22. Name and Address of Facility ELINE FUNERAL HOME 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. 11824 Reisterstown Rd. Reisterstown, MD 21136 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events anding physician and use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☑ 9 ☐ Unknown detached the 9 Unknown Hospital or Attending Physician; The law requires that the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Yes neec 24b. Were autopsy findings available 24a. Was an page 2 has prior to completion of cause of death? autopsy performed autops certificate 2 No Yes 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: HOSPICE 1 Yes 2 No Other: 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 24 hours after death.

Funeral Director, After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No filled in by the ☐ Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check within 2. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year,

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			amend # <b>1_</b> State	<sup>9</sup> Brate W					/lental Hy	giene			
			Registrar  1. Decedent's Name (First, Middle, La		Certificate	tificate of Death Reg. No.					1	37239	
	Physicia			, , , , ,			Koch			2. Date of Death Month Day Year November 21, 2011 06:02 A			3. Time of Death 06:02 A M
40 Ja	Medic Examin		4a. Facility Name (if not institution, give			4b. City, Town, or Location of Death			Novemi	$\neg$	County of Dea		00.02 A
Service of the Servic		Morningside House of Friendship				На	anover			Anne Arundel Co.			
8.	Funeral Director		5. Social Security Number 6. 8		ge (In yrs. last birth	day) If Under Months		Jnder 24 Hrs. burs Min.	8. Date of Birt (Month, Day		C	ountry)	ce (State or Foreign
10			Usual Residence of Decedent	1 □ M 2 🛣 F	95	rs.			11/20/	1916		MA "	
	/land f shov	Director	10a. State 10b. County		10c. City, Town	or Location		•	·			10d	Inside City Limits
	Man 28a-			Anne Arundel Glen Burnie									1 Yes 2 X No
Maryland 21215-0036	e filed within 72 hours after death with the Maryland that Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ral	10e. Street and Number			10f. Zip				10g. Citiz	zen of What C		
		Funeral	611 Elizabeth  11. Marital Status	Road 12. Was Decedent	Ever in U.S.	13. Was Decede		1061 ic Origin? (Spe	ecify Yes or No-	1	U 14. Race - Am	.S.	
	fter de , or it	To Be Completed by F	1 Never Married 2 Married	Armed Forces?  1  Yes 2 1  If Yes, Give		13. Was Decede			Rican, etc.)	- [	Black, Whi		
	ours af tural" al Exa		3 X Widowed 4 □ Divorced	Year or Dates.		1 L Yes 2	No Sp	ecify:			Specify:	Wł	nite
15	72 hc n "na fedic		15. Decedent's E (Specify only highest gi		(	Decedent's Usual Give kind of work ife. DO NOT use	done during	most of worki	ing	16b. Kir	nd of Business	s/Indus	try
212	within giene.		Elementary/Secondary (0-12)	College (1-4 or	5+)	ire. DO NOT use	Manage	ع <b>ت</b>			R	eta	<b>i</b> 1
pu	filed val Hyg		17. Father's Name (First, Middle, Last)						e (First, Middle, i	Maiden S		cca	11
yla	ild be Ment narker atic e		James Waterman					Maude '	Trudeau				
Mar	2 shou h and 7 is n traum		19a. Informant's Name/Relationship (1			Mailing Address				-			
as a	of and 2 should be file of Health and Mental F item 27 is marked or other traumatic even		Mr. Peter J. Koch 20a. Method of Disposition	7 5011		305 Wye Disposition (Name		<del></del>	Date		Mary J		1 21122 State
Baltimore,	permit. Page 1 a Department of F Important: If ite any injury or ot		1 Burial 2 XCremation 3 4 Donation 5 Other (Speci	Removal from State	cemetery	crematory or other	her place)		- 1		-		
altii	permit. F Departm Importa any injul		21. Signature of Funeral Service Licen		ALIAIII	ic Crem			27/11 gleton				Maryland mation
m	8 <b>2 2 5</b>		Markle. V	aum_	M01357				_				, MD 21061
П			23a. Part 1. Enter the disease, or com shock, or seart failure. List only of	plications that cause one cause on each lin	d the death. Do no e.	t enter the mode	of dying, suc	ch as cardiac o	r respiratory arre	est,			proximate terval Between
4.	Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	. Foul	we -	to +1	rive					Or	nset and Death
			resulting in deatily	Due to (or as	a consequence of	):							
		dical Examiner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of	1						9	१५०००.
p	uted nd ransit		Cause Enter Underlying Cause (Disease or injury that initiated events  C. Hyporlensum C. Hyporlensum							any yours			
λ,	ate be executed ohysician and the burial-transit		resulting in death) Last  Due to (or as a consequence of):								-		
200		edic		l d									
Box 687	ss that the death certifica igned by the attending p be detached for use as '	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							Od Data of de	ti me	
30X	eath of atter		in the past 12 months?	4 Pregnant a	2 Fetal death at time of death	3 Ectopic pr 5 Other (spe					3d. Date of de Month	Da	y Year
O. E	t the d by the	hys	9 🗌 Unknown	g ∐ Unknown				_					
, P.O.	ss that igned be de	Completed by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death										
rds	equire been s hould								1 🗆 Y	es 2 🔽	No 3∐F	Probabl	y 4 🗌 Unknown
oce	has b								24a. Was a autop: perfor	sy	24b. Were au prior to death?	itopsy compl	findings available etion of cause of
Ě	sician: The law is certificate has build lirector, page 2 s		25. Was case referred to medical	-			00 Diana	D	1 Tes	2 No	1 🗌 Ye	s 2[	□ No
Víta	ysicia is cert direct		examiner? 1  Yes 2  OHO	Hospital:	ent 2  ER/Outp	natient 3 DOA	Othori	Death (Check	oniy one) me 5 ☐ Reside	anca 6 \$	VOther (See	eiful T	ssisted
Division of Vital Records,	ng Ph fter th ineral		27. Manner of Death  1 Natural 5 Pending	28a. Date of inju (Month, Day	ry 28b. Tin	ne of 28	c. Injury at work?		8d. Describe ho			Juy) I	TATHE
	tendii Jeath. tor: A the fu	Medical Certificate:	2 Accident Investigation 3 Suicide 6 Could not b	М									
i≷i	or At after of Direct		4 Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Ω	spital spital nours neral y filled		29a. Certifier 1 Certifying Phy.	sician: To the best of	mv knowledge, de	ath occurred at t	he time date	and place an	d due to the car	ise(s) and	manner as s	tated	
	to the <b>Propriat</b> or <b>Artendring Priystician</b> : The law requires that the wirthin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.		(Uneck 2 L Medical Exam	iner: On the basis of ease Practitioner: To the	xamination and/or i	nvestigation, in m	v opinion, dea	th occurred at	the time date an	d place a	and due to the	causes	s) and manner stated.
			29b. Signature and title of certifier	2 -		29c. l	License numb	oer		gd. Date	signed (Mont	h, Day,	Year)
Doodorld								11-21-11.					
	8	- 1	30. Name and address of person who				- D •	- 0:	100 61	-		1.00	21061
	State		Mirza M. Nusairee 31. Date filed (Month, Day, Year)	#32 Registra	.401 Madi ar's Signature		k Drive	e, Ste	100 G1	en B	urnie,	MD	21061
	Registra	ır	31. Date filed (Month, Day, Year) NOV 2 2 2011	Denne	A. 4	arked							

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 26 per verb., g921.11./22/2011dhb
Certificate of Death
Reg. No. 1 - For State Registrar 37241 Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death 3:49 AM Physician/ Medical or Location of Death 4c. County of Death **Examiner** Baltimore rede. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours Min. Director 1 M 2 F 8-30-1966 of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director Battimore 1 ¥Yes 2 ☐ No 10e. Street and Number 10f, Zip Code ō 10g. Citizen of What Country? Funeral items 23a 21225 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status 14. Race - American Indian, Black, White, etc 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify "natural". Blac 3 Widowed 4 Divorced Completed Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than dary (0-12) College (1-4 or 5+) ashier Be and Mental ဂ္ permit. Page 1 and 2 should be Department of Health and Men Important. If item 27 is marke any injury or other traumatic Jac 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 MBurial 2 Cremation 3 Removal from State Baltimore, MD 4 Donation 5 Other (Specify) 21. Signa re of Funeral Service Licens 23a. Part 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of lach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): that the death certificate be executed sician and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23h Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Year 1 Yes 2 No is certificate has been signed by the director, page 2 should be detached 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown しいinision of Vital Records, Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Family Friend's Other (Specify) Home Hospital: 2 No Other: 1 🗌 Yes ပ 4 Nursing Home 5 Residence 6 1 Inpatient 2 ER/Outpatient 3 DOA this 24 hours a er death.
Funeral Director: After this etely filled n by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 Yes 2 No Accident
Suicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 6 6 29d. Date signed (Manth. Day, Year) person who completed cause 32. Red 31. Date filed (Mo State Registrar

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Year Linda Michelle Lee Medical 2011 10:00a 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3410 Duvall Avenue Apt. 1 Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 214-68-3062 **Director** 1 □ M 2 🗓 F 57 May 12, 1954 Mary.land Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director N/A Baltimore 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important if frem 27 is marked other than "" any injury or other traumatiitems 23a 3410 Duvall Avenue Apt. 1 21216 **USA** 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cultan, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: Black Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary\_(0-12) College (1-4 or 5+) Hospitals/Nursing Homes Housekeeper 11th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Raymond Lee Mary F. Jacobs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn Rowe - Daughter 3410 Duvall Avenue Apt.1Baltimore, MD. 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11/19/2011 Dundalk, Maryland 4 Donation 5 Other (Specify) Trinity Cemetery 21. Signatur of Funeral Service Licensee 22. Name and Address of Facilit Chatman—Harris Funeral Home Wabash Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Convertice resulting in death) Medical Due to (or as / consequence of) **Examiner** Sequentially list conditions, Examine ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Day signed by the at id be detached fo Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 performed? death? this certificate 1 ☐ Yes 2 🔀 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be Other: 4 Nursing Home 5 AResidence 6 Other (Specify, 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No after death. Director: After 28d. Describe how injury occurred 1 Natural 5 Pending injury filled in by the ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4  $\square$  Homicide determined Hospital To the Hospital within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 🗌 3 🔲 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Registrar Ce	artment of Health and Me rtificate of Death	Reg. No	2011 37243					
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last)  Ralph J. Liberatore		2. Date of Death Month Day Year 3. Time of Death November 10, 2011						
	Examin	ner	4a. Facility Name (If not institution, give street and number)  1003 Movrison Blud.	4b. City, Town, or Location of Death Havre de Grace	40	: County of Death Harkord					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth (Month, Day, Year,						
	Director		220-12-9171 1X M 2□F 84 Yrs. Usual Residence of Decedent	Months Days Hours Min.	10/31/192	7 Maryland					
	arylan show		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits 1 1 Yes 2 □ No					
	88a-1	Funeral Director	MD Harford Havre  10e. Street and Number	de Grace	140-0						
	with t	ā		10f. Zip Code 21078	log. Ci	tizen of What Country?					
	death ms 23	era	1003 Morrison Blud.  11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - American Indian,					
36	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-1 show Tre Madical Enerther must be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, White, etc.  Specify: White					
Maryland 21215-0036	72 hour	ted t	3 ☐ Widowed 4 ☐ Divorced Year or Dates: ₩₩ 1 1 15. Decedent's Education (Specify only highest grade completed) 16a. Dec	16b. F	16b. Kind of Business/Industry						
2	Aithin 7.00.	mple	Elementary/Secondary (0-12) College (1-4or 5+)								
7	Hygie Hygie ther t	Be Completed	12 G. 17. Father's Name (First, Middle, Last)	OVERNMENT 18. Mother's Name	(First, Middle, Maider	Civil Service					
lan	dental rked o	To Be	Pasquale Liberatore	Lucia Di							
lar	2 short and h is ma		19a. Informant's Name/Relationship (Type, Print) (Daughter 19b. Mai								
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healih and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 23a or 28a-1 show many injury or other traumatic event, it is Madical Examinating mail be notified at once.		- SYMETE	6 Bonnie Drive, Abe		Cyxana 21078  .ocation - City or Town, State					
Baltimore,				matory or other place)							
Ħ		i	*4 Donation 5 Other (Specify)  Mt. Erin Cemetery 11/18/2011 Havre de Grace, MD  21. Signature of Funeral Home, P.A.								
m —	Depa Impo any is	ic i				re de Grace, MD 2107					
Records, P.O. Box 68760, ₹	Physician /Medical Examiner per prival transit	ical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	er leading to	O Conoliae	Inferval Between Onset and Death					
	The law requires that the death certificate bate has been signed by the attending physic page 2 should be detached for use as the b	by Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year					
	quires that in signed b uld be deta		Part II. Other significant conditions contributing to death but not resulting in the	significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	The ław requir ate has been si page 2 should	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death; 1 1 Yes 2 No					
Vital	icien: sartific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)						
0	Attending Physicien: r death. sctor: After this certifici	T.	The state of the s								
	th. : After	tion	1 Mailural 5 Pending (Month, Day Year) Injury Work?  2  Accident investigation M 1 Yes 2 No								
	in Signal	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, s building, etc. (Specify)	8f. Location (Street a City or Town, Stat	Location (Street and Number or Rural Route Number, City or Town, State)						
	To the Hospital or within 24 hours after the Funerel Dir completely filled in I		29a. Certifier  (Check only 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	To the Hi within 24 To the Fi complete	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.  29b. Signal we and title of certifier	29c. License number		ate signed (Month, Day, Year)					
)	T W T		Me la Au 101 WILL	D33099	230. 50	11412211					
\	OX/		30. Name and address of person who completed cause of death (Item 23a) (Type		7 KJON.	MD 21921					
	Sta	_	1 POMICA SURT 155 West 31. Date-flood Month, Day, Xear Survey S. Garden	, , ,	7 [ ]						
	Registr	ar	to a coll peroms p. popular								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37244 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 17, 2011 8:45 November Mary L. Leizear **Medical** 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 827 Meadow Road Severn 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 579-48-3743 Director 1 M 2 X X 9/8/1933 Washington, D.C 78 Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2XXNo MD Anne Arundel Severn 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral 21144 USA 827 Meadow Road 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc. Armed Forces Black White etc. 1 Never Married 2 Married 2 XNo Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. Printing Binder Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of မ Louise Consorti Dominic Clements other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a it item 27 is Severn, MD 21144 Mr. Melvin Leizear / Husband 827 Meadow Road Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ō Department Important: I any injury or 11/19/2011 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation Signature of Fund Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 M01121 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or compli-shock, or heart failure. List only on Interval Between Onset and Death on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Pregnant at time of death the by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? Yes 2 No 1 ☐ Yes 2 🗗 No filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending r death. 2 No Accident
Suicide Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ٥

State Registrar 30. Name and address of person

31. Date filed (Month, Day,

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 06-2011

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37245 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3:12 PM 2011 November John G. Lenhoff, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 219-28-3910 **Director 1XX**M 2 □ F 79 7/5/1932 MD Usual Residence of Deceder "natural", or items 23a or 28a-f show dical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location death with the Maryland 10a State Director 1 Tes 2 YNo MD Anne Arundel Severn 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 1604 Redhaven Court 21144 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces 1 Never Married 2 X Married þ Saltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes XX No Specify: Specify: White 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Electrical Engineer Defense Contractor Be Department of Health and Mental H Important If Hem 27 is marked oth any injury or other traumation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Dorthea Fisher John G. Lenhoff, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21144 Mrs. Martha Lenhoff / Wife 1604 Redhaven Court Severn, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 ☐ Burial ※XX Cremation 3 ☐ Removal from State 11/19/11 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Atlantic Crematory 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signatur or Heral Service Lice see Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 101220 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Acute disease or condition Medical resulting in death) 484,00 **Examiner** Sequentially list conditions Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months? Month Day 9 Unknown 9 Unknown s been signed by t should be detact Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed? certificate 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗹 Inpatient 2 🗌 ER/Outpatient 3 DOA eral Director: After this filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No hours after death Accident Suicide Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a To the Funeral C Medical Leftifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number HU00048 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 31. Date filed State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ LOCKLEAR Month Day ENNETH Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death IARbon Mosp. N/A ( home ocial Security Number f Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) N.C. **Funeral** 1 🖪 M 2 🗆 F Months Days Hours Mir 240 68 9564 66 Month Pay, Year 1945 Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location the Maryland 10d. Inside City Limits Director Anne Arundel Glen Burnie 1 Yes 2 XNo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 403 W. Ordnance Road Apt. 303 21061 U.S. filed within 72 hours after death 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. 3 Widowed 4 Divorced Completed Specify: American Indian 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 8th College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important; If item 27 is marked other the any injury or other transmitted. Self-Employed Richards Auto Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bryson Locklear Marion Hunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melisa Miller / Daughter 403 W. Ordnance Road Apt. 303 Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 11/21/2011 4 Donation 5 Other (Specify) Bavview Crematorv Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARdIAC ARRYthm disease or condition modiate Medical resulting in death) Due to (or as a consequence of) <sup>4</sup>Examiner HYPERKALEMIA DAYC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events YE AN END STAGE RENAL DISCAY attending physician and for use as the bunal-tran Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year Pregnant at time of death Unknown signed by the a 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CORNER MTERT DISEASE Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si DIABETES Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No HYPENTER S.C. certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Certificate: To 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No in 24 hours are. The Funeral Director: Afternated filled in by the funeral filled in by the fune Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4  $\square$  Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one Certifying Nurse Practioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and atle of certifier D0061438 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDREW 3001 tzm.D Honoven St

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mary Christine Lane 6:10 A. M November 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Glen Burnie Anne Arundel Marley Neck Health & Rehab. 9. Birthplace (State or Foreign Country) N.C. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🗆 M 2 🔀 Months Days (Month, Day, Year) 10/09/1914 97 238 09 0476 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County the Maryland Director N/A Baltimore 1 X Yes 2 No Marvland 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral within 72 hours after death with 4214 Curtis Avenue 21226 U.S. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc 1 Yes 2 No 1 Never Married 2 Married β Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 1 and 2 should be filed within 72 hours aft f Health and Mental Hygiene. item 27 is marked other than "natural", Specify: White 3 x Widowed 4 ☐ Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home 6th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Richards Sarah Setzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Heyliger / Daughter 307 - 17th Avenue Baltimore, Maryland 21225 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entombment 11/22/2011 Baltimore, Maryland Cedar Hill Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence or). attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the burnicleted filled in by the funeral director, page 2 should be detached for use as the burnicleted filled in the statement of the property of the page 2 should be detached for use as the burnicleted filled in the page 2 should be detached for use as the burnicleted filled in the page 2. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 🖰 No 1 🗆 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes T Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 2 Accident 5 Pending Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical ifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and Atle of 29c. License number 29d. Date signed (Month. Day, Year) 8 no completed cause of death (item 23a) (Type, Print State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 17,18 per fh,g921,11/22/2011dhb Certificate of Death Reg. No. For State Registrar 37248 1. Decedent's Name (First, Middle, Last) 2, Date of Death Physician/ 05:30A M NOVEMBER 2011 LUERY RUTH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE NORTH OAKS PIKESVILLE 6. Sex If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours 1 □ M 2 🛚 F 220-07-2961 **Director** Yrs. 90 07/29/1921 NC Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location ms 23a or 28a-f sho must be notified at Director 1 🗌 Yes 2 🗶 No MD BALTIMORE PIKESVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 725 MT WILSON LANE, 21208 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian event, the Medical Examiner Armed Forces? 1 ☐ Yes 2 🖾 No Black, White, etc. ö 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: WHITE If Yes. Give "natural", Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) OWNER FOOD permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, # Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) P Joseph Rache1 UNKNOWN HIRSHFIELD **UNKNOWN** UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 BOUTON GREEN, BALTIMORE, JOSEPH LUERY / SON 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BNAI ISRAEL CONG. 11/18/2011 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License. PIKESVILLE, MD 21208 8900 REISTERSTOWN ROAD, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COPP Prograteian/ 460NR disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). burial-transif Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Other (specify) 4 Pregnant : 9 Unknown Pregnant at time of death signed by the at Id be detached for 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? ischemit cardiony spethy 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2: autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 42 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2-No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Novert 17,2011 ク37573

DHMH 17 Rev 06-2011

State

Registrar

30. Name and address of person who complete

NOV 22

JCF 31. Date filed (Month, Day, Year,

Needs

MD

South

Batte

MD

Z 1209

Ave

cause of death (Item 23a) (Type, Print)

2832

Registrar's Signature

11-08485 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Brenda Priscilla McClellan State of Maryland / Department of Health and Mental Hygiene 2011 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death Medical Examiner Month 4a. Fācility Name (if not institution, give street and number) 1858 hrs November 11, 2011 4b. City, Town, or Location of Death 4c. County of Death 1141 West Cross Street **Baltimore** 5. Social Security Number **Funeral** 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Months Davs Hours Min 2-34-1412 1 M 2 V F Yre Country) Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show Examiner must be notified at once. 1 Yes 2 No more, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10e, Street and Number 10g. Citizen of What Country? Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? White, etc. 1 Never Married 2 Married 1 Yes Yes, Give Year 4 Divorced 1 Yes 2 No specify: ۾ or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) d other than ", the Medical 1 achover 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maid Be injury or other traumatic event, 10 (SISH, 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. te, Zip Code) 586 S. Bee 20b. Place of Disposition (Name of cemetery, Baito MD Method of Disposition 20c. Location - City or Town, Burial 2 Cremation 3 Removal from State crematory or other place) rarrison 4 Donation 5 Other Specify: Forest Ow ings 21. Signature of Funeral Service Licensee Hor 5 23a. Part I. Enter the disease, or complications that caused the death. Do not **Physician** the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval failure. List only one cause on each line. /Medical a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical attending physician of UNPENDED x AMENDED 24a, per me, g922 12-8-11 sm IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 1 Live birth 2 Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death?

Records, P.O. Box 68760, The law requires that the death certificate be Division of Vital

signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an has autopsy performed? certificate the Hospital or Attending Physician: director, 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other4 Nursing Home 5 Residence 6 ✔ Other: Scene After this DOA 1 V Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🗹 Natural Director: / 5 Pending 1 Yes 2 No Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) November 12, 2011

death?

1 🗸 Yes

37249

een Onset and

Yea

24b. Were autopsy findings available prior to completion of cause of

Death

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

State 31. Date filed (Month, Day, Year) Registrar

29b. Signature and title of certifier

32. Registrar's Signature NOV 2 2 ORIGINAL

29c. License number

O.C.M.E.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Serard Middletor		Si 1- For State Registrar	ate of Maryla		artment o <i>rtificate</i> o		nd Menta		Reg. No. 20	11 3725	
Physicia Medical Examin		1. Decedent's Name (First, Midd Gerard Middl						2. Date of De Month Novemb	eath Day Year er 19, 2011	3. Time of Death 0925 hrs	
		4a. Facility Name (if not institution Johns Hopkins Hospit		4b. City, Town, o	r Location of		4c. County of D				
Funeral		Social Security Number		7. Age (In yrs. i	ast birthday)	If Under 1 Ye			Birth(MM/DD/YYYY) 9		
Director		214-15-5038	1 X M 2 F		41 Yr	Months Da	ys Hours	Mar .	29, 1970	country) Mary land	
v any	ł	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Loca	tion				10d. Inside City Limits	
ryland ia-f show	ctor	Maryland Cal	vert		Chesa	peake Be T 10f. Zip Code	each	1	10g. Citizen of What	1 Yes 2 No	
rith the Maryland 123a or 28a-f sho 10otified at once	Director	3810 16th Stre	et			2073	32		USA		
eath wit	uneral	11. Marital Status 1 X Never Married 2 M		edent Ever in U. rces? 2 X No				n? (Specify Yes or No Puerto Rican, etc.)	lo- 14. Race - A White, e	merican Indian, Black, tc.	
s after d		3 Widowed 4 Div	orced If Yes, Give Year		1	Yes 2 N			Specify: W		
5 72 hour in "natu	leted	Elementary/Secondary (0-12)	College (1		during m	nt's Usual Occupa nost of working life	e. DO NOT us	se retired)		ŕ	
215-0036 be filed within 72 hours a mital Hygiene. riced other than "nature ent, the Medical Exami	Completed	10 17. Father's Name (First, Middle	Last)		Auto	motive [		ing Name (First, Middle	Autome , Maiden Surname)	otive	
1215 d be file fental H	å	Mark Middleton Nellie Stuart									
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked nither than "matural", ar items 23a or 28a-f she injury ar other traumatic event, the Medical Examiner must be notified at once	٩	19a. Informant's Name/Relations  Mark Middleto		ather				er or Rural Route No Mary Land	-	state, Zip Code)	
Ore, ges I and of Heal		20a. Method of Disposition 1 Burial 2 Cremation		20b. I om State	crematory or of			Date	20c. Location - Cit		
altim mit. Pag partment portant:	ŀ	4 Donation 5 Other S		Met ns Grego		matory I		11/22/11		re, Maryland	
m ឱឹ≜ ឨ Physician	_	23a, Part I. Enter the disease or	Zluw-	-	Do not enter t	99 Frede	rick F	Road Balti	Imore, Mary	cyland 21228	
/Medical Examiner		failure. List only one cause Immediate Cause (Final disease	on each line.						,	Between Onset and Death	
		or condition resulting in death)  Sequentially list conditions,	Due to (or as a b.	consequence o	f):			10			
	Examiner	if any, leading to immediate Due to (or as a consequence of):  cause From Undarlying Cause (Disease or injury that initiated C.									
ansit	Exar	events resulting in death) Last Due to (or as a consequence of):  d.									
tO, e be executed ysician and burial - transit	ledical	X UNPENDED	AMENDED 2			g923 1-2	6-12 s	sm			
Ox 6876( eath certificate attending phys for use as the b	2 I	IF FEMALE: 23b, Was decedent pregnant in the past 12 months?	ne 1 Live bi		2 Fe	etal death 3	Ectopic p	pregnancy	23d. Date of del Month	ivery Day Year	
Box 6876 death certificat the attending phy defor use as the	Physici		known 9 Unkno	ant at time of de wn	ath 5 O	ther (Specify)					
that the detache	百百百百百百百百百百百百百百百百百百百百百百	Part II. Other significant condit	lons contributing to	death but not re	esulting in the	underlying cause	given in Part			e to the cause of death?  Probably 4  Unknown	
rds, Frequires	leted	-						24a. Was	s an 24b. Wen	e autopsy findings available to completion of cause of	
Reco The law cate has	Completed							perf	ormed? deat		
Division of Vital Records, tal nr Attending Physician: The law requir rs after death.  al Director: After this certificate has been silled in by the funeral director, page 2 should the contraction of the funeral director.	o Be	25. Was case referred to medica examiner?  1 ✓ Yes 2 No	77 7 7 7	npatient 2	ER/Outpatient		Othon	heck only one)	Residence 6 C	Other:	
ding Phy.	⊢t	27. Manner of Death	28a. Date of (Month,		28b. Time of	Injury 28c. Inju	ury at Work? Yes 2 ☐ N		how injury occurred		
Vision or Attendent ter death in extor:	Certification:	2 Accident Inves	stigation	of Injury - At he	ome, farm, stre	et, factory, office		28f. Location		r Rural Route Number, City	
Division the Hospital nr At hin 24 hours after the Funeral Direct poleticly filled in by	_	4 Homicide deter	rmined (Specify)					or Town,			
To the Hospital within 24 hours To the Funeral completely filled	edica	one) 2 Medical Exa	miner: On the basis o and manner st	f examination a					use(s) and manner as e and place, and due t	to the cause(s)	
	Σ	29b. Signature and title of certifie	er .	, A		29c. Licen: O.C.	se number M.E.		29d. Date signed November 20		
1 Of para	-	30. Name and address of person									
' '	ate		Assistant Medica	al Examiner gistrar's Signatu		Baltimore Stre	et, Baltim	ore, MD 21223			
Regist	rar	31. Date filed ( <i>Month, Day</i> , Ye <i>ar</i> )	Deserra	1. 1	ake						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11 Month Donald Lee Malinow 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4925 Tartan Hill Road Baltimore Perry Hall 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Days **Director** 217-54-1618 1 🛛 M 2 🗆 F 61 Yrs 02-27-1950 South Carolina Usual Residence of Deced 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director must be notified 1 Yes 2 X No Maryland Baltimore Perry Hall 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 4925 Tartan Hill Road 21128 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 ģ 1 Never Married 2 X Married 1 Yes 2 X No 3altimore, Maryland 21215-0036 1 Tes 2 No Specify. "natural" Completed 3 ☐ Widowed 4 ☐ Divorced Specify. WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) Health and Mental Hygiene. tem 27 is marked other tha Sales Manager Telecommunications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Irvin Malinow Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once. Pamela Malinow - WIFE 4925 Tartan Hill Road, Perry Hall MD 21128 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 K Cremation 3 Removal from State 4 Donation Other (Specify) 11-21-2011 Baltimore Maryland Crematory INC . Signature of Funera 22. Name and Address of Facility Cremation Society Of Maryland INC 299 Frederick Road, Baltimore MD 21228 1. Enter the disease, or complications that caused the deam. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ 4005 disease or condition resulting in death) Medical Due to (or as a donsequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) **To the Hospital or Attending Physician:** The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Day Pregnant at time of death 2 No 9 Unknown g 🗌 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 100 ည 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Director: A ☐ Accident Investigation 1 Yes 2 No Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier within 24 ho

To the Fune

completely f (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of o 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar EAST

RD

BALTO, MIS

JOPPA

4136B

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RILL

MOR

ANN

filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ No owens Medical Eacility Name (if not institution give street and number) **Examiner** Baltimore andallstown tosoice 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Month Director 1 M 2 F 56 6-30-195 28a-f show items 23a or 28a-f sho ler must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MT more 1 Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? Funeral 21207 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Medical Examiner Black, White, etc. or þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Blac "natural", 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life<del>. DO</del>NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. ndary (0-12) College (1-4 or 5+) traumatic event, the bmestic Be ther's Name (First, Middle, Maiden Surname) ည ship (Type, Prin Daughter) al Route Number, City or Town, State, Zip Code, Department of Health Plant in Important: If it MD 21229 nowens 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Ph∤iin/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) burial-1 physician s the burial Physician/Medical The law requires that the death certificate be Box 68760 ast IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Pregnant at time of death Month Dav Year the 9 Unknown P.O. s been signed by the should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page perform certificate 2 🗆 No Yes 2XIN 1 🗌 Yes director, Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 4 Nursing Home 5 Residence 6 Other S Other: 1 🗌 Yes 2 **W**No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 Natural 5 Pending (Month, Day, Year) М 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined Medical Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier only one 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie dress of person who completed cause of death (Item 23a)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Day 128A Physician/ cal Novemb Medical 4a. Facility Name if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 16 Mare HOJP, ta 8. Dale of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours 213-28-4306 Director 1 **X** M 2 □ F **WOLINA** or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b County 10a, State Director 1 Yes 2 No 10g. Citizen of What Country? Street and Numbe 10f. Zip Code ms 23a or must be r Funeral or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian 11. Marital Status and Mental Hygiene. is marked other than "natural", or iter raumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married 2 No by Yes 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates 3 ▼Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) grade completed) (Specify only highest 3e andary (0-12) College (1-4 or 5+) Be Maryland 's Name (First, Middle, Maiden Surname be g Address (Street and Number Department of Health Important: If item 27 Baltimore, 20b. Place of Disposition (Name of 20c Location -1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) injury or permit. 21. Signatura of Funeral Serv 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Atherose Physician/ disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): sician and burial-trans Due to (or as a consequence of): resulting in death) Last physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the attending p as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death ed by the a detached f 2 No 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Records. Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has to director, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural injury 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) lace of Injury - At home, farm, street, factory, office building, Ic. (Specify) determin Medical Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 3 29b. Signature and title of certific le ompleted cause of death (Item 23a) (Type, Print) Boutimore MD 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death edent's Name (First, Middle, Last) Month Physician/ Medical Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner mALLO 5 102 500 A19 bul ID Baltimore If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Age (In yrs. last birthday) 6. Sex **Funeral** Director 1 M 2 1 nklahoma 28a-f show 10b. County 10c. City. Town or Location Director Examiner must be notified 1 Yes 2 No Itimore 10g. Citizen of What Country? 10f. Zip Code o Funeral 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 12. Was Decedent Ever in U.S. Armed Force Black, White, etc. þ 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 ₩idowed 4 Divorced Completed other traumatic event, the Medical 16a, Decedent's Usual Occupation
(Give kind of work done during most of working life. DQ NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other traumation. College (1-4 or 5+) Be 18 Mother's Name (First, Middle, Maiden Surnam 17. Father's Name (First, Middle, Last) ၉ 19a. Informant's Name/Relationship (Type, Pri 1.501 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Memoratory Donation 5 Other (Specify) 21. SignAture of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the moderal dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ nota disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day Other (specify) Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 13515761 examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living 2 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one of certifie 29b. Signature and tit 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 512 4105 32. Registrar's Signatur State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 19ay 2011 Nov Physician/ Cynthia J. Miles Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death
Middle River Examiner Baltimore Ivy Hall Nursing Center Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 219-30-2086 Days Hours F@bth, 92 Year 934 Months Country) 1 🗆 M 2 💢 MD Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland notified at Director Middle River Baltimore MD 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? o must be Funeral 21220 23a 3506 Wagon Train Road items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. er than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 be filed within 72 hours after If Yes, Give Year or Dates 1 Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) own home Homemaker 12th event, Be 18. Mother's Name (First, Middle, Maiden Surname) Helen Kalning 17. Father's Name (First, Middle, Last) is marked of ပ Clinton Smith traumatic 1 and 2 should bit Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3506 Wagon Train Road Baltimore MD John L. Miles Jr./husband Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 Gardens of Faith 11/23/11 Rossville MD 1 🔀 Burial 🗿 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility 300 MAce Ave. Balto. MD Home of Essex 21221 Connelly Funeral Part 1 Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) **Examiner** Thrive +0 Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death.
Funeral Director, After this certificate has been signed by the attending physicis P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav 5 Other (specify) Pregnant at time of death ed by the a Unknown been signed by should be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an cate has I autopsy Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 2 ပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 2 Accident iniury 5 Pending Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 3 only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D61907 mk s eath (Item 23a) (Type, Print) Avenue Bultimore MD 21221 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 201 37256 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert McDonald Leo November 19. 2011 1:50 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Towson Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Numbe 219–62–0896 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 57 **Director** 1**X** M 2 □ F 03/23/1954 MD 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director notified MD Baltimore 1 X Yes 2 No 10f. Zip Code 21206 10g. Citizen of What Country? ms 23a or must be n 0 Funeral 421 01d Home Road items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Black, White, etc ō by 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates. Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.

The 127 is marked other than "natural", or sure if item 27 is marked other than "natural", or uny or other traumatic event, the Medical Examinury or other traumatic event, the Medical Examinury and the sure of the sure Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 XDivorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Automotive Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ၉ MdDonald, Sr. Roberta Moran Bernard 19a. Informant's Name/Relationship (Type, Print)

Karen Stratmann / Fiancee o. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 421 Old Home Road, Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Department of Important: If any injury or once. Chesapeake Crematory 11/21/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Dorpta Marshall 22. Name and Address of Faci Maryland Cremation Services PO Box 1413. Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death -YMPHOM Physician/ DYZARS disease or condition Medical Examiner resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transi Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò DISORDER Seizure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s performe completely filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence ည 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifie ww address of person who completed cause of death (Item 23a) (Type, Print) VORTH-CHARLOS STREET BALTIMORE MOZIZO Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Rebecca J. Mears 2011 20, 4:02 Рм November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🏋 F Days Hours Min March Day Yea Months 78 1933 West Virginia **Director** |220–38–5166 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location the Maryland notified at 10d. Inside City Limits Director 1 Yes 2 🔀 No Maryland Harford Fallston ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Funeral 2343 Choate Road 21047 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-\0036 Specify: White 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Treasurer Maryland Permalite Rebecca Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Chester White Laurel Russell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dean Mears / Son 2103 Hampshire Drive Fallston, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. Data 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Highview Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) 2011 Fallston, Maryland Syna ure of Funeral S polo Evans Funeral Chapel & Cremation Service-BelAir M00261 3 Newport Drive Forest Hill, Maryland 21050 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner nelemonio Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury that initiated events and -transit Exam death certificate be executed Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year 1 ☐ Yes 2 ☑ No 9 ☐ Unknown the a 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, Completed Thes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 1 Yes 2 No Yes 2 No Hospital or Attending Physician; Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: \_2 No Other: |2 within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 0 11/21 2011 10063270 GEORGE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ISCKA RUS MPPER CHESAPEAKE DR. BEL 32. Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 37258 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Month Day 1248 PM MCCLEAN ARNALDO 17 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Univ. of Maryland Mc - Shock Trauma Center Baltimore, MO 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours n/a **Director** 1**X**□M 2 □ F 80 12/08/1930 Nicaragua Usual Residence of Deceder 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits notified at Director 1 Yes 2 XNo Corozal 10f. Zip Code Ь 10e, Street and Number 10g. Citizen of What Country? must be r with Funeral Calcutta Village n/a er than "natural", or items the Medical Examiner mu hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married б Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates TX□ Yes 2 □ No Specify: Specify: Mixed 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working 2 should be filed within 72 in and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Church 4 Pastor Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname, ၉ Eduardo McLean Carmen Mendez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Alba McLean-Wife po Box 1503 Belize City, Belize Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2  $\square$  Cremation 3  $\square$  Removal from State 4  $\square$  Donation 5  $\square$  Other (Specify) cemetery, crematory or other place) San Juan Village Cemetery 11/30/2011 Corozal 22. Name and Address of Facility Witzke Funeral Home Inc. <u>5555 Twin Knolls Road. Columbia, MD 21045</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Subdural Hematoma disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** 58hr 48min Fall Sequentially list conditions, if a y leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) PRINCIPION APPROVED BY Exami • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director, After this certificate has been signed by the attending physician and Due to (or as a consequence of): attending physician a I for use as the burial-Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death signed by the a ld be detached for 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 autopsy 1 Yes 2 No 25. Was case referred to medica Division of Vital 26. Place of Death (Check only one) Be Hospital: ည 1 X Yes 2 🗌 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 A Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 
Natural 5 Pending work? 1 ☐ Yes 2 🗷 No Fall out of 2004M 2 🗷 Accident Investigation 15/2011 filled in by the 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) lace of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Home Fulton, MD 7446 tree drive Cherry Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 01388 17 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21201

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State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Beg No. 20 | 1 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ <sup>Day</sup> 2011 McKelvin Nov. 18, ам Patricia 6:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Dundalk 316 Pinewood Rd. 8. Date of Birth (Month, Day, Year)

Feb. 15,1941 If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In yrs. last birthday) 212-36-2021 70 Director 1 M 2 X F Md. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits at Director notified 28a-f s Md. Baltimore Dundalk 1 Yes 2X No 10e. Street and Number 10f. Zip Code or 10g. Citizen of What Country? must be 21222 USA 23a B16 Pinewood Rd. items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ıral", or item I Examiner r 14. Race - American Indian, 11. Marital Status Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 3altimore, Maryland 21215-0036 1 Yes 2 No Specify white Specify: 'natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene.

item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Cashier Grocery Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Chester J. O'Leszczuk Patricia E. Wahl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 316 Pinewood Rd. Dundalk Md. 21222 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or other trau once. Walter McKelvin husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Nov. Date 1 ☐ Burial 2 ☐ Removal from State Bayview Crematory or other place) Baltimore 4 Donation 5 Other (Specify) 21 Signature 22. Name and Address of Facility | H Connelly Funeral H 7110 Sollers Point Home of Dundalk Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Litter Uniterlying Cause (Disease or Injury that initiated events Due to (or a consequence of) attending physician and I for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year the a Pregnant at time of death 1 Yes 2 D signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown peen 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? has performed? Yes 2 N within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5XXResidence 6 Other (Specify) 2 No Certificate: To 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of cert 29d. Date signed (Month, Day, Year, completed cause of death (Item 23a) (Type, Print) Name and address of person who St Suite C BALTO 32. Registrar's State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20 I November 8:50 A.M McKay Rache1 Ruth Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Ingleside at King Farm Rockville 8. Date of Birth (Month, Day, ) June 30, Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 💢 F Pennsylvania Director 95 1916 579-46-6290 June Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director ns 23a or 28a-f s must be notified 1 Xes 2 No Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 701 King Farm Boulevard #753 20850 United States ral", or items? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc Š 1 X Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ D.C. Public Schools Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental Hitem 27 is marked oother traumatic eve Mental I မ Leta Pauline Sheldon Clifford D. McKay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Old Georgetown Road, Bethesda, Maryland 20814 John F. McKay/Nephew item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) November 19, Conneautville, Pennsylvania Conneautville Cemetery 2011 21. Signature of Funeral Service Lines see Robert A. Pumphrey Funeral Home, Bethesda—Chevy Chase, Inc. how tain M01530 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Endstage Congestive Heart Failure Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions Due to (or as a possequence of): cause. Enter Underlying Exami Cause (Disease or linjury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): attending physician Physician/Medical or Attending Physician; The law requires that the death certificate be P.O. Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? or Month Year Day signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has blirector, page 2 s autopsy perform death? 2 X No 2 No Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: Certificate: To 1 ☐ Yes 2 💢 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this nours after death.

neral Director: After the filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural injury work? 2 🗌 No Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a Certifier

To the Hospital within 24 hours a To the Funeral C Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death or urred at the time, date and place, and due to the cause(s) and manner as stated Gantimo 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) November 17, 2011 D4116LMD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19529 Doctors Drive, Germantown, Maryland 20874 Vinu Ganti, M.D., NOV 2 2 Date filed (Month) State Registrar DHMH 17 Rev 7/2009 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Elizabeth M. Murray November 18, 2011 10:53 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 8 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Director 579-01-9940 1 🗆 M 2 🛛 F 93 October 19, 1918 South Carolina Usual Residence of Decedent 28a-f shov 10h County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 No Maryland Montgomery Rockville 10e. Street and Numbe ь 10f. Zip Code 10a, Citizen of What Country? 23a 615 Blandford Street 20850 United States or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Examiner Elicabeth Armed Forces?
1 ☐ Yes 2 🗶 No If Yes, Give ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", 3 X Widowed 4 Divorced Specify: White Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Montgomery County Elementary/Secondary (0-12) College (1-4 or 5+ Account Clerk Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Martin Frank Pope Lena Ellen McLeod 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas E. Murray/Son 5768 Windwood Way, New Market, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2011 Silver Spring, Maryland 21. Signature of Funeral Service License Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 Miller M01173 23a. Part 1. Enter the disease, or complications (hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final Colon Physician/ cance disease or condition resulting in death) KNONN Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury ng physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred After Natural (Month, Day, Year) 5 Pending Accident Suicide 1 Yes 2 No Investigation hin 24 hours after death the Funeral Director: the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital 29a. Certifier XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 211 58681 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Cor Dr Rockville, MD Alexan de MD State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37262 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVËMBER 18,20°111 9:27A M John P. Matra, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month. Day, Year) Days Hours 064-22-3428 81 **Director** 1 **X** M 2  $\square$  F 3/17/1930 New York Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 X No Maryland Baltimore Phoenix 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ms 23a or must be r by Funeral Jarrettsville Pike 21131 U.S.A. 14010 "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black. 1 Never Married 2 X Married Yes 21215-0036 White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Aeronautical & 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Structural Engineer Engineering Be Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ John P. Matra, Sr. Pasqualina Mortelli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jarrettsville Pike Phoenix, MD 21131 14010 Mary Matra / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) EntombmentDulaney Valley Mem. 11/23/2011 Timonium, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final SEPTIC SHOCK Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ for in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 4 Pregnant Pregnant at time of death been signed by the should be detached 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ISCHEMIC CARDIOMYOPATHY 1 Yes 2 No 3 Probably 4 Unknown Be Completed RESPIRATORY FAILURE 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No has 24 hours after death. Funeral Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: မှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural iniury 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature a 29d. Date igned (Month, Day, Year) 29c. License number D 2 4 0 3 4

State Registrar

State 31. Date filed (Month, Day, Year) NOV 2 2 2

30. Name and address of person who comp TIMOTHY LOW, M.D.

A. Registrar's Signature

leted cause of death (Item 23a) (None Print) TOWSON, MD 21204

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 9:19 A Lloyd Nelson McNutt November 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Bel Air 812 Rock Spring Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Year) 1938 Days Hours 1 X M 2 □ F Oct. 29 Maryland 218-34-0235 73 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 🗆 Yes 2 🕇 No Maryland Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral 21014 USA 812 Rock Spring Road death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 X Yes 2 No Black, White, etc. L 1215-0036 L 1215-0036 L 21215-0036 Department of Health and Mental Hygiene. Important if frem 27 is marked any injury or care. 1 Never Married 2X Married þ 1 ☐ Yes 2X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Residential & 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Commercial Realator Vice President Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) ည Samuel Nelson McNutt Sr. Mary Trillis Lloyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred McNutt / Spouse 812 Rock Spring Road, Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Holly Hill Mem. Gdn. 11-25-2011 Baltimore, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signa Wes 1317 Cokesbury Road, Abingdon, MD 21009 hs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so on each line. 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one ca CANCOR Onset and Death Immediate Cause (Final Priysician/ NONSHALL CRU CUNG disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last burial-transit and Due to (or as a consequence of) attending physician for use as the burial Physician/Medical vision of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 $\square$ Live Birth 2 $\square$ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ed by the atter in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an autopsy performe Yes 2 has To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director; After this certific 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of 28c. Injury at work? 1 \quad Yes Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 $\square$ Pending 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical

State Registrar

DHMH 17 Rev 7/2009

29a. Certifier

(Check only one 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

PHYSACIAN

32. Regi krar's Signature

LUM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PHELEP NEWATPUNIN

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0028412

510 CHERCHISAPIANTE DATUS, DIELARAND 21014

29d. Date signed (Month. Day, Year)

NOVENDI7 ~ 21, 2011

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November la 20:05 000 0 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Johns Hopkins Bayview Medical Ctr Baltimore Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 T Days Months Hours Min. 215-80-8055 50 Director 01-15-1961 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item——any injury or other trainments. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 3012 JANICE AVENUE 21230 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Bace - American Indian Armed Forces?
1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. by 1 Never Married 2 Married 1 Yes No Specify: If Yes, Give Year or Dates Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည YVONNE RANDOLPH JAMES E. MOORE, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 WALNUT AVENUE, BALTIMORE, MD 21222 JOSEPH M. MOORE, JR /HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State 11-21-2011 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY JAMES A. MORTON & SONS F.H., INC 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1701 LAURENS ST., BALTO., MD 21217 23a. Parly. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate
Interval Between
Onset and Death shock, or heart failure. List only one cause on each line. Resurator to Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner week eumonia Sequentially list conditions Examine cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and de detached for use as the burial-transity Cause (Disease or iinjury NIKNO WIN tropalmona that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical UNKNOWN Division of Wital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? hronic HARMIO 24a, Was an autopsy certificate has 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ျှ 1 X Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b, Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident
Suicide after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I

State Registrar only one)

29b. Signature and title of certifie

DNICA 31. Date filed (Month, Day, Yea. NOV

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

038176

29d. Date signed (Month, Day, Year)

2011 8

November

4940Eastern Avenue, Baltimore, MD 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37265 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav 1251 am THEWS Novembe GERALDINE 20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE HARBOR HOSPITAL Security Number If Under 1 Year If Under 24 Hrs Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 213-28-3624 1 🗆 M 2 🔀 F Months Hours 0872471930 81 Maryland Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD N/A Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral with 1 W. Conway St. Apt 608 21201 U.S.A. should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces 1 Never Married 2 Married þ 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black "natural", 3 Divorced Completed Year or Dates 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12)
6th Grade College (1-4 or 5+) Housewife N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Richard Matthews Pauline Jenkins 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 2825 N. Denham Cir., Baltimore, MD 21225 Wendy Matthews(Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) on-site Crematory 11/2011 Baltimore, MD 21. Signatue of Funeral Service Licensee Joseph Ades Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 poane art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a ATHEROSCLEROTIC disease or condition resulting in death) CARDIOVAS CULAR YEAR Medical Due to (or as a consequence of) Examiner YEAR Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of death certificate be executed for use as the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month the g Unknown g Unknown Division of Vital Records, P.O. The law requires that the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy performed? this certificate 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 A No မ 1 Inpatient 2 ER/Outpatient 3 IDOA the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) > MEDICAL DOCTOR NOVEMBER 16,2011

Registrar

State

3001 SOUTH HANDVER STREET, BALTIMORE, MARYLAND 21225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KENNETH MWATHA HAEBOR HOSPITAL

31. Date filed (Month, Day, Year) NOV 2 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ malone Month Joann 2031 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MD Balt Maryland Hospital Baltimore eneral Social Security Number Unit If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 1 M 2 X Hours Min. 70 Director Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No MD Balt Baltimore, 10e. Street and Number 10g. Citizen of What Country? Unit ò 10f. Zip Code "natural", or items 23a or edical Examiner must be Funeral RN 21215 2503 Viole+ FUENCE . Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. tant. If fem 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Specify: Completed BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) UNK UNE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. UNK UNK Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XX Burial 2 Cremation 3XX Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lig 22. Name and Address of Facility FINK FUNERAL HOME P.A. 426 CRAIN HWY SW CLEN . t/a MARYLAND MORTUARY SUPPORT BURNIE, MD 21061 M01148 23a. Part 1. Enter the disease, or coshock, or heart failure. List only mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 4nemia Sequentially list conditions Examine il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Palmuteition To the Hospital or Attending Physician: The law requires that the death certificate be executed and the bunial-tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician hed for use as the bunal Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year 2 No g Unknown Hinknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ('ava 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has k completed filled in by the funeral director, page 2 s autopsy performed Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 임 1 Inpatient 2 PER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town. State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifies (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 2

2

11-08626 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, Robert McFadden State of Maryland / Department of Health and Mental Hygiene 2011 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle\_Last) 2. Date of Death 3 Time of Death Physician/ Month Day November 16, 2011 Modical Examiner adden 1706 hrs Koben 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Maryland General Hospital **Baltimore** If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5 Social Security Number 7. Age (In vrs. last birthday) **Funeral** Foreion Director 1 M 2 F Country) Marylan Usual Residence of Decedent 10b. County iny 10c. City. Town or Location 10d. Inside City Limits Yes 2 No Man or items 23a or 28a-f show must be notified at once, Pages 1 and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes f Yes, Give Year 3 Widowed 4 Divorced Yes 2 No specify: ፩ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 abover 10 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mc vn, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mar Six 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery) 20c. Location - City or crematory or other place) 1 V Burial 2 Cremation 3 Removal from State MT. Zion Cemete Donation 5 Other Specify 5 21. Signature of Funeral Service Licenses 22. Name and Address of F = ility 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or feart **Physician** Approximate Interval failure. List only one cause on each line. Between Onset and /Medical a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease **Examine** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of). (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed AMENDED 23a,pt.II,27,per me,g923 1-31-12 sm Physician/Medical physician a W UNPENDED Box 68760. 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Ectopic pregnancy use as t Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records. P.O. 23e. Did tobacco use contribute to the cause of death? <u>6</u> 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been sector, page 2 should 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? ✓ Yes 2 No 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Other<sub>4</sub> Nursing Home 5 Residence 6 Other After this 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No death. 5 Pending the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) within 24 hours at To the Funeral D determined 4 Homicide 29a. Certifier (Check only) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E November 17, 2011 30. Name and address of person who completed cause of death (Item 234) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Zabiullah Ali, M.D. State

DHMH 17 Rev 1/2001 OCME 2006

Registra

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 37268 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Month Day November 17, 2011 1605 hrs 4b. City, Town, or Location of Death 4c. County of Death White Hall Harford If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) Months Days Hours Min. 02/03/1935 Country) MD Yrs 10c. City, Town or Location 10d. Inside City Limits White Hall 1 Yes 2 No 10f. Zip Code 10q, Citizen of What Country 21161 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) <sub>Specify:</sub>White 1 Yes 2 No specify: Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Construction Foreman 18.Mother's Name (First, Middle, Maiden Surname) Carrie Elizabeth Singleton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1322 Grandview Ct. Fallston, MD 21047 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Nov. 21. Beltsville, MD Chesapeake Crem. 2011 22. Name and Address of Facility AFA/Stephen D.Lohrmann P.A 8717 Green Pastures Dr. Balto, Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Between Onset and Death a. Contact Gunshot Wound of Head Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Fetal death 2 Pregnant at time of death 5 Other (Specify) contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? . death? ✓ Yes 2 No 1 Yes the Hospital nr Attending Physician: hin 24 hours after death. the Funeral Director: After this certifi 26.Place of Death (Check only one) funeral director, Division of Vital Other Nursing Home 5 Residence 6 🗹 Other Scene ER/Outpatient 3 DOA 28a. Date of Injury FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot self Natural FOUND: Yes 2 🗸 No Pending the Nov 17, 2011 1545 hrs 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 2817 Troyer Road, White Hall, MD (Specify) Single Family Home Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal Within 2. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) November 18, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

**OCME** 

31. Date filed (Month, Day, Year)

2

**ORIGINAL** 

32. Registrar's Signature

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A.	Physician/ Medical SARA LOUISE MALONE								Novembe	ber 18 2011   11:25 p <sup>M</sup>			
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	Funeral		9966 OAK-LEA CT.  5. Social Security Number  8362  1		e (In yrs. lasi	t birthday)	If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		9 Rinth	nlace (State	or Foreign
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(0	or ite	by Fu	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Married</li></ul>	Armed Forces? 1 ☐ Yes 2 🔀		1		ispanic Origin? (Span, Mexican, Puerto	Rican, etc.)		ck, White,		
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Baltimore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other		21. Signatur Funeral Service Licens	ee				ss of Facility BROWN CO	MMUNITY I	FUNERAI	. ном	E P.A	
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Box 68760	certifica Iding p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			7			23d. D	ate of deliv	verv	
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<u>Fall</u>	ician: The certificate rector, pag	Be C	25. Was case referred to modical examiner?	Uzzakok				lace of Death (Chec				1155	15/01/
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Division of Vital Records,	r Atter ter des rector	Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Injubuilding, etc		ne, farm, str	eet, factory, office		28f. Location (Str. City or Town,	Street and Number or Rural Route Number,			
Ö	Hospital or 24 hours afte Funeral Director illed in lated filled in lated in lated filled in lated in		On One of the Physics Blue	sician: To the best of	my knowlo	dae deeth	accuract at the time	date and place a	nd due to the caus	e/e) and man	ner se etat	ed.	
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director After this certific completed filled in by the funeral director.	Medical	(Check 2 Medical Exam	iner: On the basis of e se Practioner: To the	xamination a	and/or inves	tigation, in my opini	on, death occurred a	at the time, date and	l place, and di	ue to the ca	ause(s) and n	nanner stated.
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	Sta Registr		29b. Signature and title of certifier  30. Name and address of person who of Rames h Sabara  31. Date filed (Month, Day, Year)  NOV 2 2 2011	32. Registra	ar's Signatu	par	les .						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Shelton :40 heodore 2011 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death House Baltinore 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, O( - 0 3 If Under 1 Year If Under 24 Hrs **Funeral** 9. Birthplace (State or Foreign Months Days Year Director 71 Country) Usual Residence of Decedent 28a-f show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Yes 2 No Manylano 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21205 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed 3 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 24 Various abwered 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Blackwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura Route Number, City or Town, State, Zip Code) Garden Department of Health Important: If item 2; any injury or other to once. uane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. me and Address of Facility 32lfu, Md 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ tastah atocellal Carunona disease or condition Medical resulting in death) Due to (or as a consequence of): 5-6 mondis **Examiner** Sequentially list conditions, Due to (or as a consequence of, if any leading to miniscle cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No eral Director: After this certificate has been signed by the atte filled in by the funeral director, page 2 should be detached for Month Pregnant at time of death Dav Year Unknown 9 Unknown TH E D DORE Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate It 1 🗌 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 🗷 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🕅 Other (Specify) + OS \$71 € (1 N) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural  $5 \square$  Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 90 MGH 32. Registrar's Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mc Collum Physician/ BerTha nocomber 201 1:08A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore N/A 2130 E. Biddle St. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min. Hours Director 243-12-1234 1 M 2 X F 91 9/22/1920 N.C. Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director MD N/A Baltimore 1 Yes 2 I No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2130 E. Biddle St. 21213 USA items Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō þ 1 Never Married 2 Married 2 X No Yes Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Black "natural", Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Various Jobs 8th N/A Factory Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Annie Everett Archie B. Harlee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Tawanda Wilkens-Grandbaughter 827 Lannerton Rd Baltimore, MD 21220 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 11/22/2011 King Memorial Park Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March F/H 1101 E. North Ave. Signature of Funeral Service Licensee Baltimore, MD 21202 . Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause on e caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. luncer disease or condition resulting in death) Medical Due to ( s a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death signed by the at 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 2 🗆 No 1 Yes Division of Vital 25. Was case referred to medical Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? Other: 4 \( \to \) Nursing Home 5 \( \to \) Residence 6 \( \to \) Other (Specify, 2 No Hospital ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannet of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital of within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/on investigation, in my special section of the cause (s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier NSROJAPANIM.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21209 28355 nim N 5203 N.S. Rympaker, M.D. State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 2011 MARTIN 20:36 PM Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min 511-42-3941 69 **Director** 1 □ M 2XXF 04 08 1942 Kansas 28a-f show 10a. State 10b. Count permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked of the than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Prince Georges Forestville 1 X Yes 2 □ No MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2031 Brooks Drive #604 20747 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than '` the M Elementary/Secondary (0-12) College (1-4 or 5+) Mail Clerk Government Be 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) ဂ္ Walter Perry Trene Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gayle Francine Martin Daughter 2031 Brooks Drive #604 Forestville, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 20c. Location - City or Town, State Date 11/18/2011 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilities: FH 5126 Belair Rd, Baltimore, MD 2 Bianchi 814 Upshur St NW Washington, DC 20011 21. Signature of Funeral Service Licens Bianchi 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury and that initiated events resulting in death) Last attending physician a l for use as the burial-Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death ed by the ar 1 Yes 2 Unknown been signed the should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform this certificate Yes 2 No 2 🗆 No Division of Vital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ill 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month  $P^{\mathsf{M}}$ Elizabeth Marshall November 2011 6:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Ivy Hall Geriatric Center Middle River Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours (Month, Day, Year) Director 218-09-2143 1 □ M 2 🕱 F 93 Yrs OCT. 1, 1918 MD Usual Residence of Decedent show at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director notified 28a-f 1 Y Yes 2 ☐ No MD BALTIMORE MIDDLE RIVER 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? ms 23a or must be n ö Funeral 1300 WINDLASS DR death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. OF by 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: WHITE "natural" Completed 3 X Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the CHURCH CLERICAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked o ည WILLIAM FILLEAUX traumatic MARGARET HARTMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 201 E. HEATHER RD BEL AIR, MD 21014 JAMES HEMLING-NEPHEW 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town. State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) SACRED HEART OF JESUS! 11/23/11 BALTIMORE, MD 21. Signature of Fun val Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER AND SON, INC 6224 EASTERN AVE BALTIMORE, MD 21224 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Demarka set and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month Year Day Pregnant at time of death been signed by the should be detached 1 L Yes 2 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 onknown Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. autopsy perform death? 1 Yes 2 No 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital ဂ္ဂ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 2 Acciden
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier MD 11-21-2011 Name and address of person who completed cause of death (Item 23a) (Type, Print) ASTERN BLVD, M.D- 21221. 709 MAUKA WASERM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2

DHMH 17 Rev 06-2011

Registrar

Leslie Anne Mildenberger

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	_		Certific	ate of	Death			Re	eg. No.		
Physiciar Medical Examin	Physician/ adical Examiner  1. Decedent's Name (First, Middle,Last)  LESLIE ANNE MILDENBERGER  2. Date of Death Month Day Year November 16, 2011								ear	3. Time of Death 0052 hrs			
		4a. Facility Name (if not institution 110 East Centre Street		umber)		4	b. City, Town, o Baltimore	r Location o	of Death		4c, Count	y of Death	1
Funeral		5. Social Security Number	6. Sex	7. Age (	In yrs. last bin	thday)	If Under 1 Yea			B. Date of Bir	th (MM/DD/YY)	(Y) 9. Bir Foreig	thplace (State or
Director	-	215 15 2462 Usual Residence of Decedent	1 M 2 X F		37	Yrs.	I WOTHERS Day	75 Hours		02 27	1975		untry) MD
r any	- 1-	10a. State 10b. County		10	c. City, Town	or Location	on						10d. Inside City Limits
Maryland 28a-f show	힑	MD 10e, Street and Number			Ва	Ltim				144	0. 0	Mark	1 Yes 2 No
with the Maryland ns 23a or 28a-f sho be notified at once.	Director	110 Centre S	St.				10f. Zip Code	212	02	10	Og. Citizen of V	S.A.	ntry ?
h with t	Funeral	11. Marital Status	12. Was De		er in U.S.		Decedent of Hi	spanic Orig	in? ( Speci		14. Rad		can Indian, Black,
		1 Never Married 2 M 3 Widowed 4 Div	1 Yes	2 X	No No		Yes 2 X No			, 5.5.,	Specify		√hite
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36 hin 72 than "	Completed	Elementary/Secondary (0-12)	College (	1-4 or 5+)			gement		,		Trade	er J	ne's
5-00 led with		17. Father's Name (First, Middle,	, Last)		1 -	lana	50	18.Mother's	s Name (Fi	rst, Middle, N	Maiden Surnam		00 0
MD 21215-0036 12 should be filed within 7 12 should be filed within 7 127 is marked other than market cont, the Medica	90	19a. Informant's Name/Relations	Joseph J	ohn	Milde	enbe	rger	Reg	ina l	Mae R	emeik:	LS	, Zip Code 34952
AD 2 shou h and h 27 is n	- )	Regina Milder		- Mot	her	233	8 SE M	aster	Ave	e Por	t St I	uci	e, FL
s l and of Healt If item	Г	20a. Method of Disposition  1 Burial 2 X Cremation			20b. Place of	of Disposit	ion (Name of ce	metery,		ate	20c. Location		
Baltimore,   Department of Heal Important: If iten	L	4 Donation 5 Other Sp	pecify:			ew (	Cremat	ory	11 2	22 11	Balti	mor	e, MD
Bal permi Depar Impo injur		21. Signature of Funeral Service	Licensee			16	9 Rivi	s of Facility .era	GJ ( Driv	Gonce e Pa	Funer saden	al a. M	Home, PA ID 21122
Physician /Medical		23a. Part . Enter the disease, or failure. List only one cause		caused the	e death. Do no								Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Acute Sub			hage							Death
		Sequentially list conditions,	b Ruptured B										
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1876 rtificate ing phy		IF FEMALE: 23b, Was decedent pregnant in the past 12 months?	23c. If yes, 1 Live I		of pregnancy 2	Feta	al death 3	Ectopic	pregnancy		23d. Date of Month		y Day Year
by the attending physiched for use as the burnel of the bu	) SICE	1 Yes 2 No 9 V Unk			e of death	Oth	er (Specify)						
C the transfer of	5	Part II. Other significant condition			ut not resulting	g in the ur	derlying cause	given in Par	rt I.				the cause of death?
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on of or ath.  Tr. After the funer		27. Manner of Death  1  Natural 5 Pend	ding	of Injury n, Day,Year)	286.	Time of Inj		ry at Work? Yes 2 🔲		d. Describe h	ow injury occu	red	
Division of Vital Records, virtin 124 hours after death. To the Hospital or Attending Physician: The law requir Virtin 124 hours after death. To the Funcal Director. After this certificate has been sompletely filled in by the funeral director, page 2 should be defined.	3	3 Suicide 6 Coul	a not be	e of Injury	/ - At home, fa	ırm, street	, factory, office t	ouilding, etc	. 28f	Location (S or Town, St		ber or Ru	ral Route Number, City
y fill		4 Homicide 29a, Certifier	mined (Specify) hysician: To the be		acudodas dos	ath annues	ad at the time d	Sto and slee	20,000,000				
To the Ho within 24 To the Force completed	200	,	miner: On the basis and manner s	of examin									
	2	29b. Signature and title of certifie	er				29c. Licens O.C.	_	_				nth, Day, Year)
		30. Name and address of person	who completed cau	se of deat	rr (Item 23a)	17)	1 0.0.	141.tm.			Novembe	10, 20	11
		Russell Alexander MD	Assistant N	/ledical	Examiner	900 V	V. Baltimore	Street, E	Baltimore	e, MD 212	23		
Stat Registra	e ir	31. Date filed (Month, Day, Year)	011	egistrar's	Signature	1					OCME		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ROBERT HENRY MUELLER 10:40 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Inlet Drive Pasadena Anne Arundel If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Min 322 24 5736 **Director** 1 **X** M 2 □ F 80 09 01 1931 Usual Residence of Decedent Illinois permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 Tes 2 No MD Anne Arundel Brooklyn Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5211 Disney Avenue 21225 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, ed Forces?
Yes 2 No 1952 Black, White, etc. 1 Never Married 2 Married X Yes by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify: Completed 3 Widowed 4 Divorced 1954 Specify. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Police Officer State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Arthur Joseph Mueller Hilda Mae Pederson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Inlet Drive Robin Mueller - Son 189 Pasadena, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill 11/23/11 Baltimore, MD Cem Signature of Landal Sovice Licensee 22. Name and Address of Facility GJ Gonce Funeral Home, 169 Riviera Drive Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. CHRONI Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L retail Co.
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Yes 2 No. Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tob co use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? within 24 hours after death.

To the Funeral Director, After this certificate I completely filled in his the completely filled in hi Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Certificate: To Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify, Son's Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 \( \subseteq \text{Yes} \) Accident
Suicide 2 🗌 No Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) NIVEMBER 18, 2011 ath (hem) 23a) Type, Print 410 - A MÓ 31. Date filed (Month, Day, Year) 32. Registrar's Si State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jerry Stanley MEDERRICK November 2011 5:25 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Atlantic General Hospital Berlin Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 937 Washington, 579-46-7557 Director 74 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Worcester Ocean Pines 1 🗌 Yes 2 📝 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3108 Point's Reach 21811 United States 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify: White '57-'64 "natural" Completed 3 Widowed 4 Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) People's Drug Store Elementary/Seconday (0-12) College (1-4 or 5+) Vice President Optical Division Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) osas Arthur Otto Mederrick Bessie Sherman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3108 Point's Reach, Ocean Pines, MD 21811 Sondra Mederrick, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Judean Memorial Gardens 11/21/11 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Olney, MD f Fundral Sex รือใช้เกิดให้รู้ Hebrew Funeral Home 254 Carroll St., NW. Washington. 20012 23a. Part 1 Color the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani End Stall Consestive disease or condition resulting in death) Medical Due to (or as a consuluence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Year 1 Yes 2 S 2 🗌 No a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy Hospital or Attending Physician: The Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier 1 ⊈ Certifying Physican: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 053612 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Havey Dr Berlin MD 21811 Barer 31. Date filed (Month, Day, Year) NOV 2 2 2011 State Registrar

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mai	yland / Depa <i>Cer</i> i	irtment of H tificate of D			giene Reg. No. 2 (	111	3727	7
	P		Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day	Year	3. Time of Death	
	Physicia Medic			arthy				Novembe	<u>r 19, 2</u>	011	8:15am M	4
	Examin	er	4a. Facility Name (if not institution, give st			4b. City, Town, or			4c. County			
	Funeral		FutureCare Cherr  5. Social Security Number 6. Sex	In yrs. last birthday)	If Under 1 Year	terstown If Under 24 Hrs.	8. Date of Birth	1		lace (State or Foreign	$\dashv$	
	Director		410-30-2373	M 2 🗓 F	85 Yrs.	Months Days	Hours Min.	(Month, Day		Coun	TN	
	nd now at	7	Usual Residence of Decedent  10a. State  10b. County		Oc. City, Town or Loc	ation		Oct. 3,	1920	1	0d. Inside City Limits	$\dashv$
	anylar ka-fsl ified	Director	MD Baltimo	re	Owing	gs Mills					1 ☐ Yes 2 <b>X</b> ☐ No	
	or 28		10e. Street and Number	,10	OWIN	10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?	٦
	with ris 23a	Funeral	42 Wengate Road			211			USA			4
	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	y Ful	11. Marital Status  1 □ Never Married 2 □ Married	<ol> <li>Was Decedent Even Armed Forces?</li> <li>1 ☐ Yes 2 X N</li> </ol>	er in U.S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - Americ k, White,		
920	s after ral", o Exam	ed by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates.	1	☐ Yes 2【 No	Specify:		Specify:	V	Mhite	
2 0	"natur	plete	15. Decedent's Edu (Specify only highest grad		16a. Deced	lent's Usual Occupa	ation Juring most of work	king	16b. Kind of Bu	usiness/ln	dustry	
21215-0036	thin 72 ane. than	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		O NOT use retired)	1. 0. **		Marula	nd C	un Corn	
The state of the s										yland Cup Corp.		
/lan	d be fi	우	Rufus Underwo	ood			Ve	rna Penn	ington	ton		
Maryland	ge 1 and 2 should be it of Health and Menta it it item 27 is marked or other traumatic e		19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailin	ig Address (Street a	and Number or Rui	al Route Number	; City or Town, S	tate, Zip (	Code)	
	and 2 Health em 27 ther t		Mark Kevin McCarth 20a, Method of Disposition	ıy Son	10 W€	engate Ro	ad, Owin	gs Mills Date	MD 2 20c. Location -	1117 City or Tr	nwn State	$\dashv$
nor	Page 1 ment of ant: If it		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	cemetery, crem	natory or other place	i i	30-2011	Owings	-		
Baltimore,	T		21. Signature of Funeral Service Licenses	)		. Name and Addres					own Road	
m	permit Depar Impor any ir	- 3	JUL JU	Jagne Os		Eline Fun		e Reis	sterstow			- 13
			23a. Fart 1. Enter the disease, or compli shock, or bear failure. List only one	cations that caused to cause on each line.	he death. Do not ente		g, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death	
	Medical		Immediate Cause (Final disease or condition resulting in death)			COND				-	10915	-
	Examiner			Due to (or as a	consequence of):						1	
ďΞ		iner	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):							
	cuted ind transit	Examiner	Cause (Disease or injury that initiated events	Due to for on a	consequence of):		·					$\dashv$
_	cate be executed physician and sthe burial-transit		resulting in death) Last	. Due to (or as a	consequence on.							
2092	icate by phys	<b>l</b> edical										-
Box 687	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. was decedent pregnant	3c. If yes, outcome of	pregnancy Fetal death 3	Ectopic pregnanc	:y			Date of delivery  Month Day Year		
<b>B</b> 0)	death the att	/sici	in the past 12 months? 1 ☐ Yes 2 🔁 No 9 ☐ Unknown	4 ☐ Pregnant at t 9 ☐ Unknown	time of death 5	Other (specify)			IMC	ntn	Day Year	
Division of Vital Records, P.O.	ad by detacl		Part II. Other significant conditions cor	tributing to death but	t not resulting in the u	inderlying cause giv	en in Part I.	23e. Did to	bacco use cont	ribute to t	he cause of death?	
S,	ires the signer of signer	od by						1 🗆 ,	Yes 2 □ No	3 🗌 Pro	bably 4 🔀 Unknowr	1
ord	w requ	plete						24a. Was autop			psy findings available impletion of cause of	
Rec	The la ate ha page	Completed						perfo	rmed?	death? 1 🗌 Yes	2 No	
ta	ician: certific ector,	Be	25. Was case referred to medical examiner?	ospital:		Othe	ace of Death (Chec			· · · · ·		
Ž	Physical rather of the care direction of the care of t	2	1 ☐ Yes 2 🛣 No	1 Inpatier 28a. Date of injury		nt 3 🗆 DOA	4 Nursing F	lome 5 Resid	dence 6 Oth		/)	-
o uc	nding ath. r: After	icate	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day,	Year) injury	work	? Yes 2□No					
/isi	r Atte	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (S City or Tow		er or Rura	l Route Number,	
ā	pital o		29a. Certifier 1—Certifying Physic	ion. To the heat of m	ny kaoviladao, doath i	accurred at the time	dete and place	and due to the ca	aueo/s) and man	ner as sta	ted.	$\dashv$
	e Hos 24 ho e Fun	Medical	29a. Certifier (Check 2 Medical Examin only one) 3 Certifying Nurse	er: On the basis of exa	amination and/or invest	tigation, in my opinio	on, death occurred	at the time, date a	ind place, and du	e to the ca	iuse(s) and manner stat	ed. <sup>1</sup>
	To the vithir comp	2	29b. Signature and title of certifier			29c. License			29d. Date signe	d (Month,	Day, Year)	
			•		$\supset$		737573		noveme	ER	1105,15	_
			30. Name and address of person who co			orint) with Are	Balt	time 1	10 21	209		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	's Signature							$\neg$
	Registr	ar	NOV 2 2 2011 /2	and a	ball							- 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 19 201 Tar Physician/ Susan Jane Neighoff Nov. 6:00p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Essex Baltimore 910 Holgate Drive Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Feb. 14, 1957 Country) 218-64-2510 54 Director 1 🗆 M 2 💢 🗗 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Essex MD Baltimore 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a or ner must be n ò USA Funeral 21221 910 Holgate DRive death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 0 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 Divorced 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United Cerebral Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Food Preparation Palsy 12th Be Department of Health and Mental H, Important If item 27 is marked oth any injury or other traumant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maide Ruth Hutchins ည MArtin Neighoff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8101 Bletzer Road Baltimore MD 21222 19a. Informant's Name/Relationship (Type, Print) Emma Hutchins /aunt 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Bayview Crematory 11/21/11 Baltimore MD Domation 5 Other (Specify) 22. Name and Address of Facility 300 MAce Ave. 21. Si ./ atu; rvice Lice Connelly Funeral Home of Essex 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner DISEASE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical I or Attending Physician: The law requires that the death certificate be a after death.
Director: After this certificate has been signed by the attending physicia Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Pregnant at time of death been signed by the a should be detached f 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work?
1 Yes 2 No 2 Accider
3 Suicide Accident Investigation filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined the Hospital 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DII

DHMH 17 Rev 06-2011

State Registrar Scufe 200

PHILADELPHA

32. Registrar's Signature

BAUD MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 2 2 2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:17AM 19 2011 Leray Olson November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist
al Security Number | 6. Sex | 7 Hospital Rockville <u>Montgomerv</u> 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. (Month, Day, Year) Country **Director** 523-36-2681 1 🕅 M 2 🗆 F Usual Residence of Deceden November 9, 1931 80 0klahoma or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location irector 1 X Yes 2 No Rockville Maryland Montgomery Ö 10f. Zip Code 0 10e Street and Number 10g. Citizen of What Country? "natural", or items 23a o NOVEMBER Funeral 740 Carr Avenue 20850 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. 1 X Yes 2 ☐ No
If Yes, Give
Year or Dates. 1950—1973 þ 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced White er than "natur, the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Maryland 2121 life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) and Mental Hygiene. United States Navy Military Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Rudolph M. Olson Annabelle Neuschild 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 740 Carr Avenue Rockville, Maryland 20850 Mary M. Olson/ Wife Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place)
Montgomery
Crematorium Inc. 1 🗌 Burial 2 💢 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u>Bethesda, Maryland</u> 22. Name and Address of Facility Robert A. Rockville, Inc. 300 Wes Rockville, Maryland 208 21. Signature of Fune al Service Licenses Pumphrey Funeral Home/ t Montgomery Avenue 50-2805 Inc. 300 Maryland M00335 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final dysrhy thmia Physician Cardiac disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner disease artery covonary Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a con a quence of): yper tengion law requires that the death certificate be executed the burial-tran and that initiated events Due to or as a consequence of resulting in death) Last physician Physician/Medical Records, P.O. Box 68760 as IF FEMALE for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗌 No 2 X No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 1 No 1 Inpatient 2 ER/Outpatient 3 I DOA 1 🗌 Yes 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending work? 1 Natural iniury 5 Pending after death. Director: A 2 Accident
3 Suicide
4 Homicide Investigation the within 24 hours after dear To the Funeral Director completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 110051791 NOVember 19, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center Drive Rochville MD 20850 9901 DO 32. Registrar's Signature State Registrar

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DHMH 17 Rev 06-2011

		•	1 - For State Registrar	State of Mi	Cei	tificate of L		rivieritarri	Reg.			
ı	Physicia		1. Decedent's Name (First, Middle, L. Mattie L. Owens	ast)				2. Date of D Month <b>Nov</b>		2011	Year	3. Time of Death 3:00 P M
الماميد معيد	Medic Examin		4a. Facility Name (if not institution, gi			4b. City, Town, or Location of Death  Cheverly  4c. County of Death  Prince Georges						ges
	Funeral Director		Social Security Number     6.		e (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Min		Day, Yea	r)	9. Birthp Cou <i>n</i> i	olace (State or Foreign try) MS
	Maryland 28a-f show otified at	Director	10a. State 10b. County  DC	L	10c. City, Town or Lo	cation					1	0d. Inside City Limits  ★▼ Yes 2 □ No
	h with the ns 23a or must be n	Funeral D	10e. Street and Number  1383 Somerset Pl. N			10f. Zip Code <b>2001</b>				Citizen of Wh		try?
9000	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	b	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【○ Divorced	12. Was Decedent E Armed Forces? 1  Yes XX If Yes, Give Year or Dates.	ever in U.S. 13. \	Nas Decedent of H f Yes, specify Cuba I ☐ Yes 2 XX No		Specify Yes or No rto Rican, etc.)	)-	14. Race Black, Specify:	White, 6	etc.
21215-0036	vithin 72 hou jiene. sr than "nat the Medica	Completed	15. Decedent's (Specify only highest ( Elementary/Secondary (0-12)	t grade completed) (Give		dent's Usual Occup kind of work done o O NOT use retired) acher				16b. Kind of Business/Industry  Lauderdale Public Schoo		
Maryland 2	d be filed v Mental Hyg arked othe	To Be	17. Father's Name (First, Middle, Last	)			1115	ame (First, Middle L. DeBru		en Sumame)		
	nd 2 shou ealth and m 27 is m			Type, Print) usin		Box 281,			330			
Baltimore,	t. Page 1 al rtment of H rtant: If itel rjury or oth		20a. Method of Disposition 1	cify)	20b. Place of Dispo cemetery, cren Musgrove Ce	natory or other plac	i -	Date 19, 2011	20c.	. Location - C Enterpr	-	
Bai	Depar Depar Impor any in		21. Sign of Frank	M01148		Name and Addre Fink Funer 426 Crain	al Home,	len Burni		21061		
الح	Physician/ Medical		23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	Fatal Car	the death. Do not entered to the diac Arrythmia consequence of):		ig, such as cardia	ac or respiratory	arrest,			Approximate Interval Between Onset and Death
	Examiner	ıer	Sequentially list conditions,	Cardiomyo								
	Attending Physician: The law requires that the death certificate be executed at death.  ector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	sal Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Stage IV								
68760	ertificate I ding phys se as the	/Medic	IF FEMALE:	23c. If yes, outcome	of pregnancy					204 D-4-	- 6 - 1 - 1 i	
Вох	the death certif	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1								Day Year	
ds, P.O.	requires that the des been signed by the s should be detached	by	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	nderlying cause gi	ven in Part I.			o use contrib		e cause of death?
Division of Vital Records,	sician: The law re s certificate has be director, page 2 sh	Completed						24a. Wa aut per 1 🗆 Yes	opsy formed	pri		osy findings available mpletion of cause of 2 No
Vital	nysiciar nis certif I directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 CER/Outpatier		er: 4  Nursing	, ,	sidence	6 ☐ Other	(Specify)	
ion of	To the Hospital or Attending Physician: The la Within 24 Hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigati 3 Suicide 6 Could not	he	ry 28b. Time of injury	e of 28c. Injury at 28d. Describe how injury occurred						
Divis	pital or Ai burs after eral Direc filled in by		4 Homicide determine  29a, Certifier 1 Certifying Ph	building, etc			o data and ulass	City or To	wn, Sta	ite)		Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	(Check 2 ☐ Medical Examonly one) 3 ☐ Certifying Nu	ysician: To the best of niner: On the basis of ex erse Practitioner: To the	kamination and/or invest	igation, in my opinio death occurred at t	on, death occurre the time, date and	d at the time, date	and pla the cau	ace, and due t use(s) and ma	o the cau	ise(s) and manner stated tated.
	<b>5</b> ≥ <b>6</b> 8		29b. Signature and title of certifier	epus	1	D27	25>7	•	29d. [	Date signed (	2/	vay, rear)
			30. Name and address of person who Ophnell Cumberbato	h 3001 Hos	pital Dr., Ch		20785					
1	Stat Registra	te ar	31. Date filed (Month, Day, Year) NOV 2 2 20	11 Personal Property of the Pr	r's Signature	Kel						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 37281 Reg. No. 20 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Wallace Wlodzimierz Jan Pawlak November 20, 2011 9:20 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Casey House Social Security Number 8. Date of Birth
(Month, Day, Year)
Aug 5, 1939 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign **Director** 385-52-5110 1 **X** M 2 □ F Poland 72 death with the Maryland at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified MD Montgomery Silver Spring 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1915 Agate Drive 20904 USA ural", or items ? 12. Was Decedent Ever in U.S. Armed Forces?

1 

Yes 2 

No

No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced Year or Dates 1969-94 Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) ed other than " event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Physician US Military/Healthcare Mental Hygi Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental Hitem 27 is marked of other traumatic even ဂ္ Jan Pawlak Irena Frakala 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cam Pawlak/wife 1915 Agate Drive Silver Spring, MD 20904 other 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Final Journey Crematory 11/22/11 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Lie 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Pancreatic Cancer Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the burial-transi that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy ρ 5 Other (specify) Month Day Pregnant at time of death Year signed by the a 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1  $\square$  Yes 2  $\square$  No 3  $\square$  Probably 4  $\square$  Unknown After this certificate has been significate has been significated and former and director, page 2 should 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 X No completely filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner 1 ☐ Yes 2 🗶No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA hospice 4 Nursing Home 5 Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After (Month, Day, Year) 1 X Natural 5 Pending Accident
Suicide М 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 22, 2011 D37142

State

Registrar
DHMH 17 Rev 06-2011

31. Date filed (Month, Day, NOV 2 2

Yearl

2011

Coleman, M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ANTE 530AM November 20 2011 Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death **Examiner** 4c. County of Death ver hester en 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 8. Date of Birth **Funeral** 1 🗆 M 2 💢 F Min. Feb. 13, Hours 061-38-3719 62 Yrs 1949 Director Usual Residence of Decedent show 10a. State 10b. County the Medical Examiner must be notified at 10c City Town or Location 10d. Inside City Limits Director 28a-f 1 🗌 Yes 2 💢 No Maryland Queen Annes Grasonville 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 111 Watermans Court 21638 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 l and Mental Hygiene. 7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Seamstress Dress Factory injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Menta Important. If item 27 is marked any injury or add. ၉ James McGill Geraldine Lavier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Real J. Plante (Husband) 111 Watermans Ct., Grasonville, MD 21638 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State John Bosco Cemetery 11-26-11 4 | Conation 5 Other (Specify) Malone, NY 21. Sign ture of Funeral Service Licen <sup>22</sup> Name and Address of Facility Bruso-Desnoyers Funeral Service 568 E. Main St., Malone, NY 12953 Mus 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Ph. sician/ Due to (or as a consequence of): disease or condition ecent month Medical resulting in death) Examiner Night Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying physician and sthe burial-transit that the death certificate be executed Cause (Disease or iin)ury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 4 ☐ Pregnant at time of death g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ @ Multi-Episodes of MI Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accider
Suicide Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completed fi (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 7/2009

State

/LILMum, MD

KIN K. WUN, MD

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signatur

415 Washington Ave, Chestertown, MD 21620

11/20/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37283 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 4:55 A M Gary Lee Pribble Nov. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Baltimore Dundalk 1822 Dunmere Road Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Director 218-62-4766 1 X M 2 🗆 F Nov. 25,1952 Maryland 58 Usual Residence of Decedent 28a-f show 10a. State 10b. County Director 10c. City. Town or Location 10d. Inside City Limits notified Dundalk 1 Yes 2 X No Baltimore MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ö ms 23a or must be r Funeral United States 21222 1822 Dunmere Road 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ö þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. 1 Yes 2 X No Specify: Specify "natural" Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4 or 5+) 4 Years Elementary/Secondary (0-12) Army Research Lab 12 Years Human Resources alth and Mental Hygie 27 is marked other r traumatic event, the Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ပ Evelyn Knight Percy Pribble 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 1822 Dunmere Road Dundalk, Maryland 21222 Health tem 27 Bryan M. Pribble(Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of F Important; If ite any injury or ot once. 1 X Burial 2 Cremation 3 Removal from State Meadowridge Mem. Park 11/19/2011 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23 art 1. Enter the diseas of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hepatocellular carcinoma Physician/ disease or condition resulting in death) 2 months Medical Due to (or as a consequence of) Examiner CROHN'S 20429 DISEASE Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Aseptic necrosis 10475 that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial Completed by Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has performed? Yes 2 N 1 🗌 Yes 2 🗆 No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ☑ No Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) completely filled in by the funeral 27. Manner of Death 28b. Time of Hospital or Attending P 24 hours after death. Funeral Director: After t Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) To the Hospital of within 24 hours as To the Funeral D. Medical 29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number D30494 11-47-2011 Mesa \* NESHIM

State Registrar

15

3altimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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TIC maiden choice lane 30%

Baltimore moxIXX8

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Depa	rtment of Health and N		ene 2011 37284
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death
	Physicia Medic		Ronald Koswell Powe		NOV	Day Year 11:50 PM
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	F	М	EllicottCity Health & Rehab  5. Social Security Number 6. Sex, 7. Age (In yrs. last birthday)	Ellicott City If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Howard  9. Birthplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex. 7. Age (In yrs. last birthday) 12 M 2 F 69 Yrs.	Months Days Hours Min.	0472671	942 Courte
	pug ,		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limits
	Maryli f sho	ļo	MD Baltimore Owings M			1 ☐ Yes 2 No
	n tha	Director	10e. Street and Number	10f. Zip Code	10g	p. Citizen of What Country?
	23a c	alD	9500 Side Brook Rd. Unit 303	21117		SA
336	s 1 and 2 should be filed within 72 hours after death with the Maryland of Haalth and Mental Hygiene. Item 27 is marked other than "naturel", or items 23s or 28s-f show other transmatic event, the Madical Examinat must be notified at	by Funeral	1 Never Married 2 Married 1 Yes 2 No	as Decedent of Hispanic Origin? (SIYes, specify Cuban, Mexican, Puerton Yes 2 No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify:Black
5-0	72 ho	eted	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give k	ent's Usual Occupation	kina 16	b. Kind of Business/Industry
121	within iene. than "r	Completed	Elementary/Secondary (0-12)   College (1-4or 5+)	ind of work done during most of wor O NOT use retired) Listrative	F	ederal Government
9	filled v Hygie othar t	မ င်	5+ AGIII II		ne (First, Middle, Ma	uiden Sumame)
an	Aental Aental rkad c	To B	James Edward Powell, Sr.	Hattie	Distanc	e
Maryland 21215-0036	2 should and Men is marks					City or Town, State, Zip Code) 2 1 1 1 7
	1 and Haalth am 27 othar tr					03 Owings Mills, Miloc Location - City or Town, State
nor	80 = 5		1 ☐ Burial 2 Cremation 3 ☐ Removal from State cemetery, crem	les Gram	. 22, Be	eltsville, MD
Baltimore,	그 문문 중			ike Crem.   20		n D.Lohrmann P.A.
ä	permi Depa Impo any Is		21. Signature of Funeral Service Licensee 22.	17 Green Past	ures Dr.	Balto, MD 21286
			23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.			Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	TURY TA	FILUR	C
	Examiner		Due to (or as a consequence of):	STAGE R	ENAL ]	DREARC
	D =	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
D.	icate be executed physician and the burial-transit	Examlner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
8760,	sician buria	cal E				
9	tificate ng phy as the	b	U			
P.O. Box	law requiras that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown		23d. Date of delivery Month Day Year	
	is that gned b	by Pt	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
ord	w require been sig should b				1 🗆 Yes	2 No 3 Probably 4 Unknown
Division of Vital Records,	0 - 0	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
alE	ilcian: The l certificate ha		25. Was case referred to medical	00 Plant of Par	1 ☐ Yes 24	
Ž	yalcian: is certific director,	To Be	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Other .	th (Check only one) ome 5 ☐ Residen	ce 6 ☐Other (Specify)
0 0	Attanding Phyalcian: r death. ector: After this certific. by the funeral director,		27. Manner of Death 28a. Date of Injury 28b. Time of (Month, Day Year) Injury	28c. Injury at Work?	28d. Describe how	injury occurred
isio	ttandi death. stor: A	catl	2 Accident investigation	M 1 Tyes 2 No	28t Logation (Stro	et and Number or Rural Route Number,
Div	after after I Direct	Certification:	4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide	et, factory, office	City or Town,	
	To the Hospital or Attant within 24 hours after deatt To the Funaral Director: completely filled in by the	edlcal C	29a. Certifier  (Check only one)  Certifying Physicien: To the best of my knowledge, death of the death of th			
)	To t withi To tl	W	29b. Signature and fulle of certifie	29c. License number  D 00627		d. Date signed (Month, Day, Year)  NOV 21, 201)
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, F	ye Rd #100 Ellic	- A   A   C   2	LIN
		te	31. Date filed (Month, Day, Year)  32. Registrar's Signature	JE KO THOO EILL	COTT CIT	4 112
	Sta		NOV 2 2 2011 Burn D. Saves			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Powell Month Isaac 2011 14:00 Medical 4c. County of Death Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Randallstown Examiner Season's Hospice Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 217-24-5393 **Director** 1 🕱 M 2 🗆 F 81 80 23 30 MD 28a-f show within 72 hours after death with the Maryland at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director items 23a or 28a-f s ser must be notified Baltimore MD NA 1) Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3208 Carlisle Ave 21216 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner o Black, White, etc by 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Black "natural" Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) other than 12th grade College (1-4 or 5+) Hygiene the Airforce Man Air Force Be iled \ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed trrent of Health and Mental H rtant: If item 27 is marked ot ည Albert Powell Agatha Foote 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ella S. Powell-Wife 3208 Carlisle Ave, Baltimore, Md 21216 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of I
Important: If ite
any injury or ot Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Donation 5 Other (Specify) Forest 11/30/2011 Owings Mills, Md Garrison of Funeral Service Ocensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or healt failure. List only one cause on each line. rval Between Immediate Cause (Final Union Death Ph. sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine Due to for selection recommends cause. Enter Underlying Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): the attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year detached 9 Unknown ģ s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Muddy mass 24b. Were autopsy findings available prior to completion of cause of death? Was an certificate has autopsy pade performed? Yes 2 4No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? of Other (Specify) Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence s after death.

Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ce 29d. Daty signed Month, Day, Year) KAMEN W-WHUTTIMD

State

Registrar

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	State Registrar	e of Maryland	•	rtment of Heal tificate of Deat		,	giene Reg. No. 2	2011	37286
	Physicia Medic		1. Decedent's Name <i>(First, Middle, Last)</i> Nacmi Spight P	ettiford				2. Date of Dea Nov 19,		Year	3. Time of Death  1:10 P. M
	Examin		4a. Facility Name (if not institution, give street and Bradford Oaks Nursing			4b. City, Town, or Locat			4c. County of Death Prince George's		
	Funeral Director		5. Social Security Number 430 26 8229 6. Sex	7. Age (In yrs. last	birthday) Yrs.		nder 24 Hrs.	8. Date of Birth Nov 16,	1918	9. Birth	place (State or Foreign
	À	or	Usual Residence of Decedent  10a. State  10b. County	10c. City, T	ity, Town or Location 10d. In						10d. Inside City Limits
	Maryl 28a-f otifie	Funeral Director	Maryland Prince George's	C	linton		<u></u>				1 ☐ Yes 2XX No
	ith the 23a or st be r	ralD	10e. Street and Number 4925 Plata Street			10f. Zip Code 20735				n of What Cour United St	
	death v	Fune	11. Marital Status 12. Was	Decedent Ever in U.S. d Forces?	13. V	/as Decedent of Hispanio Yes, specify Cuban, Mex	c Origin? (Spec	cify Yes or No-		Race - Americ	can Indian,
030	e filed within 72 hours after death with the Maryland tal tyygene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	1 Never Married 2 Married 1 If Yes	Yes 2 X No , Give X No or Dates.			ecify:	noun, oto.y	Spe	Black, White, ecify:	lack
9500-612	2 hour "natur	Completed	15. Decedent's Education (Specify only highest grade comple	T		ent's Usual Occupation ind of work done during	most of workir	ng I	16b. Kind	of Business In	
1212	vithin 7 iene. r than th Me	Com	Elementary/Seconday (0-12) College 12	ge (1-4 or 5+)		NOT use retired)  W Clerk			Civil Rights Com		ts Com
ng	I be filed within 72 hours after death with the Maryland fental Hygiens 1. The other than "natural", or items 23a or 28a-f sho tre event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)					(First, Middle, i	Maiden Sun	name)	
Maryland	nould be fill and Mental marked amatic ev		Charles McCray  19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street and No		Spight Route Number	: City or Toy	vn. State. Zip i	Code)
Ž.	nd 2 sh ealth a m 27 is er trau		Arthur Pettiford (Son)			Small Drive,			-		
ore	permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en once.		20a. Method of Disposition 1 ☐ Burial 2 🗶 Cremation 3 ☐ Removal	from State cerr	netery, crem	sition (Name of attory or other place)		ate	20c. Locat	tion - City or To	own, State
Baltimore,	permit. Pa Departme Importan any injury once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Sign tu  f Funeral Service Licensee	Lee	Cremat 22	Ory . Name and Address of F	1919	3, 2011   Emercal			Old ALexandria
n	9 3 E 8 9		Davis L. Voas	m00257		erry Road, Clir	nton, MD	20735		110 0000	C - Minerally DA-OZOGO
	hysician/		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause of immediate Cause (Final	nat caused the death. In each line.  Andrewood		the mode or dying, suc		r respiratory am	est,		Approximate Interval Between Onset and Death
أرسيد	Medical Examiner		resulting in death)	e to (or as a consequer		7,130	7300				
		Jer	Sequentially list conditions, b. ———————————————————————————————————	e to (or as a consequer	nce of):					_	
	cuted nd transit	Examiner	Cause. Enter Underlying Cause (Disease or iinjury that initiated events  c								
_	icate be executed physician and s the burial-transit	edical E	resulting in death) Last Du	e to (or as a consequer	nce ot):						
8/60	tificate ng phys as the	Medi	IF FEMALE:								
Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death.  To the Funeral Director: Affer this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?	s, outcome of pregnanc Live Birth 2 ☐ Fetal d Pregnant at time of dea Unknown	death 3	Ectopic pregnancy Other (specify)			230	d. Date of deliv	very Day Year
л Э	that th ned by e detac	by Ph	Part II. Other significant conditions contributing	to death but not result	ting in the u	nderlying cause given in	Part I.	23e. Did to	bacco use	contribute to t	the cause of death?
rds,	een sig nould b							15			obably 4 Unknown
or Vital Records,	he law r te has b age 2 sh	Completed						24a. Was a autop perfo	rmed?		opsy findings available ompletion of cause of
ta ta	cian; T sertifica ector, p	8 B	25. Was case referred to medical examiner?				Death (Check		2 11 110	1 2 103	2010
<u> </u>	y Physi er this c eral dire	e: 10	27. Manner of Death 28a.		8b. Time of	28c. Injury at		me 5 Resid			(y)
ono	eath. or: Afte the fun	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year)	injury	M 1 ☐ Yes	2 🗆 No				
DIVISION	al or Att s after d i Direct d in by		4 Hamisida determined 286.	Place of Injury - At homoulding, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (S City or Tow		umber or Rura	al Route Number,
_	e Hospita 24 hours e Funera eleted fille	Medical	29a. Certifier 1 Certifying Physician: To (Check 2 Medical Examiner: On the only one) 3 Certifying Marse Practic	e basis of examination a	and/or invest	igation, in my opinion, dea	ath occurred at	the time, date a	nd place, ar	nd due to the ca	ause(s) and manner stated.
	Voithi To th		29b. Signature and title of certifier  William Course			29c. License num	her	1	20d Date s	igned (Month	Day Year)
			30. Name and address of person who completed	cause of death (Item 2:	3a) (Type, P	LVington	Rosel	futi	UPS H:	ytm.	21.2011 may/m/
	Sta Registr		31. Date filed (Month, Day, Year)  NOV 2 2 2011	32. Registrar's Signatur	re	•					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State of Registrar		artment of Health and I	Mental Hygien	71111 31701			
7%	Physici /Medio Examir	cal	1. Decedent's Name (First, Middle, Last)  Rīchad An Hubl  4a. Facility Name (If not institution, give street and num		OK &  4b. City, Town, or Location of Death	11 2	Year (OTel M			
,	Funeral Director		220-22-6550 1XIM 2 F	7. Age (In yrs. last birthday) 81 Yrs.	Westminster  If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea May 27, 1				
036	be filed within 72 hours after death with the Maryland ntal Hygiene.  ad other then "naturel; or items 23a or 28a-f show event, it a Medical Examination must be notified at	by Funeral Director	Usuaf Residence of Decedent	dent Ever in U.S. 13. es? 2 □ No	Bridge  10f. Zip Code  21791  Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No-	10d. Inside City Limits  1 □ Yes 2 ▼ No  Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify:  White			
21215-	<ol> <li>Pages 1 end 2 should be filed within 72 fment of Heelth and Mental Hygiene.</li> <li>Item 27 ie marked other then mailury or other traumatic event.</li> </ol>	e Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  Colfege (1- 12  17. Father's Name (First, Middle, Last)	(Give life.	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)  11er & Instructor 18. Mother's Nar	rking	Kind of Business/Industry  lecommunications en Surname)			
Marylan		To Be	Joseph George Petrask  19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street and Number or Ru		or Town, State, Zip Code)			
0		Betty Ann Petraska Wife 419 Clear Ridge Road, Union Bridge, MD 2179  20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Fungraf Service Liceasee  22. Name and Address of Facility  23. Value of Disposition (Name of cemetery, crematory or other place)  24. Signature of Fungraf Service Liceasee  25. Name and Address of Facility  26. Place of Disposition (Name of cemetery, crematory or other place)  27. Signature of Fungraf Service Liceasee  28. Name and Address of Facility  29. Name and Address of Facility  20. Location - City or Town, Society or T								
			1-1882	used the death. Do not en	line Funeral Home	Reisters				
,760,	Physician /Medical /M	lical Examiner	disease or condition resulting in death)  Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  C.	or as a consequence of): or as a consequence of): or as a consequence of):	ABRIC Area	nysa				
	death certific e attending p od for use as	by Physician/Med	in the past 12 months?	int at time of death 5(	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year			
Records, P.	v requires that been signed should be de	eted by Ph	Part II. Other significant conditions contributing to dea	ath but not resulting in the t	underlying cause given in Part I.		obacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Minknown			
	Physician: The lav this certificete hes ral director, page 2:	Be Completed	25. Was case referred to medical examiner?	/	Othor	autopsy performed:  1 Yes 2 2 1  ath (Check only one)				
vision of	i or Attending Phys after death. Director: After this of in by the funeral dir	Certification; To	27. Manny of Death 1 Platural 5 Pending investigation 3 Suicide 6 Could not be determined	f Injury , Day Year) 28b. Time o Injury	M 1 Yes 2 No  Ime, farm, street, factory, office 28f. Location (Street and Number or Rural					
	Hospite 4 hours Funeral	Medical Cer	29a. Certifier  (Check only one)  1 Certifying Physician: To the la 2 Medical Examiner: On the ba and mann	sis of examination and/or ir	th occurred at the time, date and place ovestigation, in my opinion, death occu	e, and due to the cause urred at the time, date a	o(s) and manner as stated. and place, and due to the cause(s)			
) A	To the within 2 To the complete	Σ	29b. Signature and title of certifier  30. Namerand address of person, who completed cause	of death (Item 232) (Type	29c. License number 03900	MN 29d. [	Date signed (Month, Day, Year)  H   20   1    WESTMINSTEL MM			
	Sta Registr		STED HOCAIN	ngistar's Signature	EAST MA	TIN ST	WESTMINSTER MY 21157.			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Stephanie Potyraj NOvember 2011 7:44  $P^{M}$ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6727 Railway Avenue 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign **Funeral** Days Hours **Director** 213-01-8545 1 □ M 2 □**X** 91 Maryland November 6,1920 Usual Residence of Deceden or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Dundalk 1 🗆 Yes 2 Ϊ No Maryland 10e. Street and Number ō 10f. Zip Code ms 23a or must be n 10g, Citizen of What Country? with 1 Funeral 6727 Railway Avenue 21222 USA items 2 within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner r 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. þ Maryland 21215-0036 1 Yes 2 XNo Specify. Specify: White 3 X Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than alth and Mental Hygiene. 27 is marked other than r traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 12 years 2 Years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jozef Szymkowiak Katarza Niec Page 1 and 2 should? ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trauonce. Paul Potyraj 4201 Riversedge Way, Dundalk, Maryland son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State November 1 X Burial 2 Cremation 3 Removal from State Sacred Heart of Mary Cem. Dundalk, Maryland 23, 2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. omplications that caused the death to not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. 23a. Part 1. Enter the disease, shock, or heart failure. Lis Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Oroyan Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) that the death certificate be executed attending physician and burial-tra Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death Yes 2 10 be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, the Hospital or Attending Physician; The law requires abetes 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 hours after death. Ineral Director: After this certificate 1 Yes 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita 2 1100 Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a

To the Funeral E

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier inpleted cause of death (Item 23a) (Type, Print) 2112 0 undall. Registrar's Signat State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 201 37289 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12:00 a<sub>M</sub> Physician/ November 21, 2011 Helen G. Philipp Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Presbyterian Home of Maryland Baltimore Towson 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours 214-20-2001 1 🗆 M 2 🗓 F 87 Director June 24, 1924 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d Inside City Limits Funeral Director Towson MD. Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 Georgia Court USA 21204 Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ "natural", or 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 3 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify: 3 X Widowed 4 Divorced Completed Year or Dates 7 is marked other than "natural tranmatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Health Care Reg. Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Lillian Sill Harold Dav 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C 7906 Old Harford Rd. Baltimore, MD. 21234 Karen Mabry/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date Department of Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State 11-23-11 Baltimore, MD. Moreland Mem. Park 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligensee 1050 York Road 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part 1. Enter the disease, pr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 5 Immediate Cause (Final Physician/ neumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Box 68760 IF FEMALE: nse 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown for Month Year Day 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Altherners Discasa Division of Vital Records, 1 ☐ Yes 2 🗙 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \sum \) Yes 2 \( \sum \) No 24a. Was an autopsy performed? Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: မ 1 Yes 2 × No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury s after dea. ral Director: Afte 5 Pending 1 Natural work? 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

To the I

complete only one) 29b. Signature and title of certifier D37016 ise of death (Item 23a) (Type, Print) St., S. te 4104 Baltimore, mo 21204 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar Kenneh M. Greek, MD

31. Date filed (Month,

Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible

			For State	State of Ma		i / Depa		Health and	•			37291
			Registrar  1. Decedent's Name (First, Middle, Last)			Cer	tificate of I	Death		Reg. No.	011	
	Physicia		Ruth	E11e	on	Do	verill		2. Date of Dea Month Novembe	Day	20 <b>1</b> 1	3. Time of Death 7:20 P M
me.	Medid Examir		4a. Facility Name (if not institution, give str		<u> </u>	16		r Location of Deatl			y of Death	1 7:20 P
-	,	J	1516 Putty Hill A		_		Balt:	imore		В	altimo	ore
	Funeral Director		5. Social Security Number  019-10-6870  Usual Residence of Decedent  6. Sex	7. Age	(In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day NOV 1	, Year 1917	Count	lace (State or Foreign try) achusetts
	show dat	tor	10a. State 10b. County	<u> </u>	10c. City,	Town or Loc	ation				1	0d. Inside City Limits
	Mary 28a-f otifie	Director	Maryland Baltimor	e	В	altimo	ore					1 Yes 2 No
	th the 3a or the n	ral D	10e. Street and Number				10f. Zip Code			10g. Citizen of		try?
	ems 2	Funeral	1516 Putty Hill A	2. Was Decedent Ev	ver in U.S.	13. V	212 /as Decedent of H		pecify Yes or No-		S.A.	an Indian
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates.	No	- 1	Yes, specify Cuba  ☐ Yes 2 X No	dispanic Origin? (Span, Mexican, Puerton Specify:	o Rican, etc.)		ick, White, e	etc.
2	2 hou "natu	plet	15. Decedent's Educ (Specify only highest grade			(Give k	ent's Usual Occup	durina most of wor	kina	16b. Kind of E	Business/Inc	lustry
12	within 7 giene. er than t, the Me	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+	+)	life. DO	NOT use retired) lesperso		9	Depart	mont	Storo
	filed will all Hygis double went, t	Be	17. Father's Name (First, Middle, Last)			Ja	resperso		ne (First, Middle,			Store
/lan	d be fi Menta arked artic ev	ပ္	Kirby	Tay	lor				Elizabet	h	Marsh	all
Maryland	should be and Menta		19a. Informant's Name/Relationship (Type			19b. Mailin	g Address (Street	and Number or Ru	ral Route Number	; City or Town,	State, Zip C	ode)
	and 2 Health em 27 ther tr		Bonnie Peverill Da	aughter	20h Plo		Putty Hi	11 Avenu				
nor	Page 1 nent of ant: If it ury or o		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cen	netery, crem	atory or other plac		Date	20c. Location	-	
Baltimore,	mit. P partm portar portar / injur		21. Signature of Funeral Service Lidensee		More		Mem. Parl		22-2011   uck Tows	on Fune	ral H	Maryland ome, Inc.
m	Depar Impor any ir		Tout the	any			1050 Yorl	k Road	Towson,	Maryla	nd 21	204
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	tions that caused to cause on each line.	the death.	Do not ente	the mode of dyin	ig, such as cardiac	or respiratory arm	est,		Approximate Interval Between
~-F	hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	000	ma	ry	w	tery	arse	ase		Onset and Death
4	Examiner			Husk	20 M	nce off:	ordo	MIL				
l L		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due (o as a	consequer	nce of):		100,00				
	e be executed ysician and e burial-transit	Examiner	Cause (Disease or injury that initiated events c.	Due to /ou or o								
	be exe	calE	resulting in death) Last	Due to (or as a	consequer	ice oi):						
	certificate to adding physuse as the		d.									
x 687	requires that the death certificate been signed by the attending phy should be detached for use as th	by Physician/Med	Zob. Was decedent pregnant	c. If yes, outcome of			Ectopic pregnance	°V		23d. Da	ate of delive	ry
Вох	the atter	ysici	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4 ☐ Pregnant at t g ☐ Unknown			Other (specify)			M	onth	Day Year
О	Ine law requires that the ate has been signed by the page 2 should be detach	y Ph	Part II. Other significant conditions contr	ributing to death but	t not result	ing in the ur	iderlying cause giv	ven in Part I.	23e. Did to	bacco use con	ribute to the	e cause of death?
S,	n sign		<u> </u>					-	1 □ Y	es 2 No	3 🗆 Prob	ably 4 🗆 Unknown
Vital Records,	iw required is bee 2 short	Completed							24a. Was a		Were autop	sy findings available
Ř	sician: The law certificate has t lirector, page 2 s	Com							autop perfor 1  Yes	med? 2 X No	death?	pletion of cause of
<u>ta</u>	ician: certific rector,	Be	25. Was case referred to medical examiner?	spital:			26. Pl	ace of Death (Chec	ck only one)			
> 1	r this eral di	e: 10	1 ☐ Yes 2 No 27. Manner of Death	1 Inpatier 28a. Date of injury		R/Outpatient	3 DOA 28c. Injun	4 ☐ Nursing H	ome 5 X Residence 128d. Describe ho			
ou	ath. r: Afte	icat	Natural 5 Pending Investigation	(Month, Day,	Year)	injury	work		Zod. Bosonbo no	ow injury occur	cu	
Division of	ore nospiral or Attending Prysician: within 24 hours affect death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.		e, farm, stre	et, factory, office		28f. Location (Si City or Town		er or Rural I	Route Number,
_ :	Prospir	Medical	29a. Certifier (Check only one) 3 Certifying Physicial Examiner	: On the basis of exa	amination a	nd/or investi	gation, in my opinio	on, death occurred a	at the time, date ar	nd place, and du	e to the caus	se(s) and manner stated.
	vithin 2 To the comple		29b. Signature and title of certifier		A .			number		9d. Date signe	•	
			Kmesho	uglas (	Ta.	rRe	MY	10031	476	11,	121,	/1/
			39. Name and address of person who com	pleted cause of dea	ath (Item 23	3a) (Type, Pr	5 Osle	7	214 7	owsor	. 44	712016
	Stat		31. Date filed (Month, Day, Year)	32 Registrar	1 P	150	2 ~1/6	rur,	- / /	000501	1/100	× 21204

State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Leacock Month Day Physician/ 10-510 35 PM 6. Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Bon Secour 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex **Funeral** Min 1 🗆 M 2 🔀 F Hours S.Carolina 0170971952 59 214-56-2581 **Director** Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location death with the Maryland 10a, State Director must be notified 1 XYes 2 No Baltimore N/A MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21217 U.S.A. 23a 2118 Pressbury St. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?
1 ☐ Yes 2 ☐ XNo Black, White, etc. ò 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black If Yes, Give "natural", Completed 3 Widowed 4 Divorced Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Woodburn Center Counselor 9th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H 27 is marked of traumatic ever permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked cary injuy or other traumatic evenore. Ella Louise Willis ည Ellison McCrae 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3420 St. Ambrose Ave., Baltimore, MD21215 Sylvia Barnes(daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) /19/11 Baltimore, MD on-site Crematory 予めを責任。 Prown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21. Signature of Funeral Service Licenses MD 21217 um 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) to (or a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 🗌 Yes 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1. Yes 2 □ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 1 Department 2 ER/Outpatient 3 DOA မ this Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner eath 28b. Time of 28d. Describe how injury occurred Certificate: 24 hours after death.
Funeral Director; After i leted filled in by the funeral iniury Natural 5 Pending Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Iberal MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FALLS 419 12500 L 32. Registrar's Sanature State

DHMH 17 Rev 7/2009

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	1- For State Registrar	Cer	tificate of Dea	th	Reg	j. No.	
Physician/	Decedent's Name (First, Middle,La	st) R o	herten		Date of Death     Month     November	Day Year	3. Time of Death 1736 hrs
Godi Examiner	Jay reh	ve street and number)	4b. City,	Town, or Location of Deat		4c. County of Death	
	University Hospital	•	Baltin	more			
Funeral Director	11999	6ex 7. Age (In yrs. Ia	yrs. If Unc	der 1 Year If Under 24Hr hs Days Hours Min		Foreig	thplace (State or gn untry)
Maryland 28s-f show any Lat once.	Usual Residence of Decedent  10a. State 10b. County  10e. Street and Number	10c. City,	Town or Location  Baltir  10f. Zi	ND CL	100	g. Citizen of What Cou	10d. Inside City Limits 1 Yes 2 No
with the Maryland ms 23a or 28a-f sho be notified at once eral Director	1918 Bur	12. Was Decedent Ever in U.	s 13. Was Deced	21239 ent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Amer	ican Indian, Black,
fter death with 1", or items 23 ter must be no y Funeral	1 Never Married 2 Married 3 Divorce	Armed Coreen		ify Cuban, Mexican, Puerto		White, etc.	act
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once Be Completed by Funeral Director	15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or 5+)		Occupation (Give kind of orking life, DO NOT use ref		16b. Kind of Business/	Industry
ID 21215-0036 should be filed within 72 hour and Mental Hygiene. 7 is marked other than "matunatic event, the Medical Exam To Be Completed	17. Father's Name (First, Middle, Las	2		18.Mother's Nam	e (First, Middle, Ma	Fast	Food
D 2121; should be fil and Mental I 7 is marked 1 attic event, I	19a. Informant's Name/Relationship	Tope, Print)	19b. Mailing Addres	s (Street and Number or	Rural Route Numb	er, City or Town, State	, Zip Code
nd 2	Mr. Brandon  20a. Method of Disposition		5501 G Le Place of Disposition (Na		Date Date	246 Atlant 20c. Location - City or	Town, State
	1 Burial 2 Cremation 3 4 Donation 5 Other Specia	- Kellioval Ilolli otate	rematory or other place	netery 111	26/11	Dundalt	C. MD
Baltimo permit. Page Department o Important: injury or ott	21. Signatu of Funeral Service Lice	Gray	Name and	Address of racility	S. Fun	and Home	P.A. D 21216
Physician /Medical	23a. Parti. Ent., ihe disea, or con failure. List only one cause on Immediate Cause (Final disease			of dying, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
£xaminer	or condition resulting in death)	Due to (or as a consequence of					
ed nsit <b>Examiner</b>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence of					
ecuted and - transit	events resulting in death) Last	Due to (or as a consequence of	r):				
760, cate be execuphysician anothe burial - tr	UNPENDED	AMENDED				. <b>.</b>	
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transiledical Certification: To Be Completed by Physician/Medical Es	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknow	23c. If yes, outcome of pregr 1 Live birth 4 Pregnant at time of deal	2 Fetal death		ancy	23d. Date of deliven Month	/ Day Year
P.O. B as that the d igned by the e detached I by Phy	Part II. Other significant conditions		esulting in the underlying	g cause given in Part I.		acco use contribute to	
ls, P quires then signe ald be d			<del></del>		1Yes	2 No 3 Prot	pably 4 Unknown
Division of Vital Records, P.(  ral or Attending Physician: The law requires that rs after death.  The Director: After this certificate has been signed led in by the fineral director, page 2 should be det  ertification: To Be Completed by					autopsy perform 1 ✓ Yes 2	y prior to oned? death?	completion of cause of
Vital Recysician: The last certificate director, page	25. Was case referred to medical examiner?			26.Place of Death (Check			
Physic rathis of all direction	1 ✓ Yes 2 No					esidence 6 Other	ri
ion of tending P eath. tor: After the funer:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investiga	28a. Date of Injury (Month, Day, Year) Nov 12, 2011	28b. Time of Injury 1649 hrs	28c. Injury at Work? 1 Yes 2 ✔ No	Subject shot	w injury occurred	
Division o spital or Attending nours after death. nours after death. filled in by the fune Certification:	3 Suicide 6 Could no determin	t be 28e. Place of Injury - At ho	ome, farm, street, factor	y, office building, etc.	or Town, Sta		ral Route Number, City altimore, MD
Division of To the Hospital or Attending Physicial 24 hours after death. To the Funeral Director: After a completely filled in by the funeral Medical Certification: The Medical Certification:	29a. Certifier 1 Certifying Physic one) 2 Medical Examin	cian: To the best of my knowledger: On the basis of examination are and manner stated.	ge, death occurred at th nd/or investigation, in m	e time, date and place, and by opinion, death occurred	d due to the cause at the time, date a	(s) and manner as statend place, and due to th	ed. e cause(s)
F * F %	29b. Signature and title of certifier		29	c. License number		29d. Date signed (Mo.	
	N-MUL -			O.C.M.E.		November 13, 20	)11
	30. Name and address of person who Donna M. Vincenti, MD	completed cause of death (Item Assistant Medical Exam		ltimore Street, Balti	more, MD 212	23	
State Registrar	31. Date filed (Month, Day, Year)	32 Registrar's Signatu	· back				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician/ Month 5:20p. Ray Jr. 2011 Lane 08 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Stella Maris Hospice If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Director 216-50-1275 1 🗶 M 2 🗆 F 62 Yrs 10 49 NC 02 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director tx Yes 2 ☐ No NA Baltimore NA 10f. Zip Code 10q. Citizen of What Country? 10e. Street and Number Funeral U.S.A 21215 4203 Fallstaff Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 🕅 Never Married 2 🗆 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black "natural", Completed 3 Widowed 4 Divorced event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72 and Mental Hygiene. Baltimore City Dept College (1-4 or 5+) ementary/Secondary (0-12) Inspector 12th grade Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If Item 27 is marked any injury or other traumatic ev once. Rose Currie Frank Ray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1919 Brookdate Road, Baltimore, Jamaur Ray-Son Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Owings Mills, Md 11/18/2011 Forest Garrison 21. Signa ur March F/H West Funeral Service License 21215 Baltimore, 4300 Wabash Ave, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 T Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No that the death Pregnant at time of death 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ or Attending Physician: The law requires 1 Tyes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed?

1 Yes 2 No death? 1 Yes 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Certificate: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No nours after death.

neral Director; After the filled in by the funera 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral L Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

11-08702 Surva Raia Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

urya Raja		State of Maryland / Department of Health and Mental Hygiene 20   3729										
Physicia	an/	1. Decedent's Name (First, Middle,Last)		-			2. Date of			3. Time of Death		
ledical Exami	ner	3		—				mber 1	9, 2011	0640 hrs		
		4a. Facility Name (if not institution, give street and num Gilchrist Hospice Center	.ber)	4	b. City, Town, Columbia	or Location of	Death		4c. County of Dea Howard	ith		
Funeral		5. Social Security Number 6, Sex 7	'. Age (In yrs. la	ast birthday)	If Under 1 Ye			of Birth (	(MM/DD/YYYY) 9. E			
Director		076-34-6817 1∑M 2□F	94	Yrs.	Months Da	ays Hours	Min. Febr	uary	21,1917 Fore	country) India		
, tr		Usual Residence of Decedent  10a, State 10b, County	Inc. City	Town or Location	n .					10d. Inside City Limits		
b de se	_	Maryland Howard	, ioo. ony,	TOWN OF EGGEN		licott	City			1 Yes 2 X No		
Maryland 28a-f show any 1 at once.	Director	10e. Street and Number			10f. Zip Code		020)	10g.	. Citizen of What Co	untry?		
eath with the Maryland items 23a or 28a-f sho		8349 Governors Run				2104	3		United S	States		
th with	Funeral	11. Marital Status 12. Was Deceded 1 Never Married 2 Married Armed Ford	dent Ever in U.S	S. 13. Was	Decedent of I	lispanic Origi an, Mexican,	n? ( Specify Yes Puerto Rican, etc	or No-	14. Race - Ame White, etc.	erican Indian, Black,		
er dear		3 X Widowed 4 Divorced If Yes, Give Year	2 X No		Yes 2 X		, , , , , ,	,		ian Indian		
urs afi tural	d by	or Dates:  15. Decedent's Education (Specify only highest grade	completed)	16a. Decedent	's Usual Occup	ation (Give k	ind of work done	10	6b. Kind of Busines:			
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withir giene.	Completed	17. Father's Name (First, Middle, Last)		Physi	cian/P	-	trist S Name (First, Mic	tdlo Mai		lical		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	ည ရှိ	Narasiah Setty Raja				1	a Lakshn		iden Suriame)			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	٩.	19a. Informant's Name/Relationship (Type, Print )		1		eet and Numb	oer or Rural Rout	e Numbe	er, City or Town, Sta			
MD and 2 sho alth and 27 is		Mohan S. Raja/Son  20a. Method of Disposition	I sob n	8349 G			, Ellico		City, Mary	71and 21043		
Baltimore, permit. Pages I an Department of Hea Important: If ite injury or other tr		1 Burial 2 Cremation 3 Removal from	- CL-L- C	rematory or oth	er place)			1	oc. Location - City o	or Town, State		
Itim it. Pagurtment ortant		4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee	Ĉre	matory	ame and Addre		November 20	111	Odenton,	Maryland		
Ban Derm Depa	Ц	Will Er Bourn	M00672	Dor 141	aldson	Funer	al Home	& Cr	cematory, on, Maryla	P.A. and 21113		
Physician	20012	23a. Part I. Enter the disease, or conflications that cau failure. List only one cause on each line.	sed the death.	Do not enter th	e mode of dyin	g, such as ca	rdiac or respirato	ry arrest	, shock, or heart	Approximate Interval Between Onset and		
∖/Medical ,Examiner		Immediate Cause (Final disease a. Aspiration										
		or condition resulting in death)  Due to (or as a condition of the conditi		-								
	ne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	onsequence of	):								
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and and transi	a E	d										
ox 68760, eath certificate be executed attending physician and or use as the burial - transfer.	edical	UNPENDED AMENDED										
Box 68760, e death certificate be the attending physic ed for use as the buri	M/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, ou	itcome of pregn th		al death 3	Ectopic	pregnancy		23d. Date of delive Month	ry Day Year		
ox 6 ath cer attendi	sician/M	4 Pregnan	nt at time of dea	ath 5 Oth	er (Specify)							
O. B. It the de by the	F.	Part II. Other significant conditions contributing to d		sulting in the ur	nderlying cause	given in Pari	t I. 23e.	Did toba	cco use contribute t	o the cause of death?		
P.C	d b	Dementia; Hypertension					1[	Yes	2 No 3 Pro	obably 4 🗹 Unknown		
rds, requires been should	ete							Was an autopsy		outopsy findings available completion of cause of		
Reco	Completed							performe Yes 2	ed? death?			
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director; page 2 should be	BB C	25. Was case referred to medical examiner?					Check only one)			Nagara-al		
F Vid	욘	examiner?  1 Yes 2 No  27. Manner of Death  Phospital: 1 Inp  28a. Date of		ER/Outpatient 28b. Time of In		Other <sub>4</sub>	Nursing Home		sidence 6 Oth	<del>o</del> r:		
ion o tending eath. tor: Aftu	ë	1 Natural 5 Pending Nov 15, 20	ay,Year)	1130 hrs		Yes 2 🗹 I	Subject	ingest	ed household	cleaner		
visic or Atte fter dea Directo	fical	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of	of Injury - At ho	me, farm, street	, factory, office	building, etc.				tural Route Number, City		
Division 2 Hospital or Attence 1.24 hours after death e Funeral Director etely filled in by the	Certification:	4 Homicide determined (Specify)	Assisted Liv	ving Facility			3417 For	wn, State thill Dri	e) ve, Ellicott City, M	ID .		
To the Hos within 24 h To the Fun completely	edical	29a. Certifier (Check only one)  2  Medical Examiner: On the basis of one)										
To the within 2 To the complet	Medi	and manner state  29b. Signature and title of certifier	led.	- C		nse number			9d. Date signed (M			
		11	-1	1/	i	.M.E.		1	November 19, 2			
2		30. Name and address of person who completed cause							OCME			
3	_	Russell Alexander MD. Assistant Me			V. Baltimor	e Street, E	Baltimore, MD	2122	3	4		
St Regist	ate	31. Date filed (Month Day Year) 32. Regination 32.	strads Signatur	arke			COME					

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•		4	State of Maryland / De		rtment of H tificate of D			, No. 2	011	37295
			Registrar  1. Decedent's Name (First, Middle, Last)	7011	mouto o. z		2. Date of Death		V	3. Time of Death
н	Physician	1/	ROBERT J. RUSSELL, SR.				Month NOV.	16 2	Year 2011	8:40A <sup>M</sup>
- Charles	Medica Examine	_	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Deatl	n		ty of Death	
-			GILCHRIST CENTER		TOWS0	ON I If Under 24 Hrs.	8. Date of Birth		TIMORE	place (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 2		Months Days	Hours Min.	6. Date of Birth (Month, Day, You 5-31-192	ear) 20	Cour	ryland
	nd thow at	ō	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	r Loc	ation					10d. Inside City Limits
	th with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	Maryland Baltimore	В	altimore	County				1 Tes 2 No
	the N a or 2 be no		10e. Street and Number		10f. Zip Code		10	9	of What Cou	intry?
	h with	ner	2343 Hamiltowne Circle	10 V		237 ispanic Origin? (S	pecify Yes or No-	USA 14. Bi	ace - Ameri	can Indian,
	r item	교	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 ▼ ▼ Yes 2 □ No WW 11		Vas Decedent of Hi f Yes, specify Cuba		to Rican, etc.)	ВІ	lack, White,	, etc.
36	al", o	d by	MX Widowed 4 Divorced If Yes, Give Year or Dates.	1	Yes 2 X No	Specify:		Speci	fy: Wh	ite
9-0	hours natur dical I	l ge	(Specify only highest grade completed) (G	Give F	dent's Usual Occup kind of work done o	ation during most of wo	rkina		Business/Ir	1
218	nin 72 ne. han " e Med	mo	Elementary/Secondary (0-12) College (1-4 or 5+)	fe. Do	O NOT use retired)				l Sec	
121	d with tygier ther t	Be Completed	12th grade N/A	TE	erk	18. Mother's Na	ame (First, Middle, Ma			
and	be file ental H ked o c eve	10	Robert D. Russell				rine R. Sc			
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		10h A	Mailir 234	ng Address(Street 13 Hamilt	and Number or R	ural Route Number, C ccle Balti	City or Town .more ,	n, State, Zip Md •	Code) 21237
	of Healt of Healt If item 2		20a. Method of Disposition  20b. Place of Disposition  20b. Place of Disposition State  20b. Place of Disposition Commenter,	crer	osition (Name of matory or other place	4				Town, State
Baltimore,	artment ortant: injury o		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee		Valley M. 2. Name and Addre		21–2011  B assahn Fu			
Ba	permi Depar Impor any ir		Months showed	74	401 Belai	r Rd. Ba	altimore,	Md. 2		
			23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t ent	er the mode of dyir	ng, such as cardia	ac or respiratory arres	st,		Approximate Interval Between Onset and Death
	Physician/		Immediate Cause (Final disease or condition a. AD VANCE	0	Deme	ENTIA				YDARS
	Medical Examiner		Due to (or as a consequence of	):						
	ped sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	f):						
	executed an and urial-transit		that initiated events resulting in death) Last C. Due to (or as a consequence of	f):						
09	requires that the death certificate be exbeen signed by the attending physician should be detached for use as the burial	Physician/Medica	d							
68760	ertifica Iding p	N/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	ا د	☐ Ectopic pregnar	nev		23d.	. Date of de	
Box	eath c atten	iciar	23b. Was decedent pregnant in the past 12 months?   1 ☐ Yes 2 ☐ No   9 ☐ Unknown		Other (specify)	icy			Month	Day Year
	the de by the tached	hys	g Unknown  Part II. Other significant conditions contributing to death but not resulting in	the.	underlying cause (	given in Part I.	23e. Did tol	pacco use o	contribute to	o the cause of death?
P.O.	s that gned be de		Chromic OBSTRUCTIVE PULM							Probably 4 Unknown
rds	een si	Completed by	Chiamic Obstitution			V-C	24a. Was a	n 2	4b. Were at	utopsy findings available
Ö	The law nate has b	du		_			autops perfor	med?	death?	completion of cause of
Ä	ician: The certificate rector, pag		25. Was case referred to medical		26.	Place of Death (C		2 NO	1010	
lita	ysician: s certific director,	To Be	examiner? 1   Yes 2   No	tpatie	ent 3 DOA	ther: 4  Nursin	g Home 5 Reside	ence 6	Other (Spe	city) HOSPICE
of.	ing Phy J. After this funeral o	te: T	100 T	ime o	of 28c. Inju	ork?	28d. Describe ho	ow injury oc	curred	
20	endin eath. or: Aft	fica	2 Accident Investigation 3 Suicide 6 Could not be 200 Place of Injury - At home far	_		Yes 2 No	29f Location (S	troet and Ni	umber or Ri	ural Route Number,
Division of Vital Becords.	I or Attendi after death. Director: A d in by the fi	Certificate:					City or Town	n, State)		
	to the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/o only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, only one)							
	To the within 2 To the I	Ψ	only one) 3 L Certifying Nurse Practitioner: To the best of my know 29b. Signature and title of certifier	wiedo	20c Licer	nse number		29d. Date s	ianed (Mon	th, Day, Year)
4	F ≥ ₹ ¤		Mul Hopes	_	De	46360	/	Na	10MB	ae/6,2011 MD 21204
0+	-1		30. Name and address of person who completed cause of death (Item 23a) (	Туре	North	Chaple	05 STRADT	- BAL	TIMELE	~MO 21204
0	St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature		in .		54			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 20, 2011 4:52 P.MM Clara ROSENBAUM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Casey House 7. Age (In yrs. last birthday) 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days 087-12-3469 1 M 2 XF Hours Dec. 28, 1921 Bromx, NY Director Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Gaithersburg MD Montgomery 1 X Yes 2 No ō 10e. Street and Number 10f. Zip Code must be r 10g. Citizen of What Country? Funeral U.S.A. 20879 9301 Broadwater Dr. ral", or items ! 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give by 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🕅 No Specify: nan "natural", Medical Exan Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Secretary Typist traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be file I and Mental I I is marked of မ Weisinger Sarah Israel Bergman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip. Code, 9301 Broadwater Dr., Gaithersburg, MD 20879 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Janet Frankel / daughter Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 X Removal from State Nov.22,2011 West Babylon, NY New Montefiore Cem 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun All Se you License 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW Washington, DC 20012 Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arractions, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Encephalopathy disease or condition resulting in death) Medical Due to (or as a consequence of Examiner M Urosepsis Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Right Hip Fracture and -trans that initiated events resulting in death) Last Due to (or as a consequence of) burial physician the burial ĵΙ Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 X No Day Pregnant at time of death Month Vear ed by the a Unknown g Unknown us been signed by ti 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed? 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 1 XYes 2 No Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1. Natural 2. Accident 5 Pending 1 Yes 2 X No 10/12/2011 unknown <sup>M</sup> Fall at assisted living Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Sunrise of Rockville, ALF 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined 8 Baltimore Rd., Rockville, MD Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number D37141 Nov. 21, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar filed (Month, Day, Year)

20850

Geoffrey Coleman, 1355 Piccard Dr., Suite 100, Rockville, MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1924 ۲*(*) 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Mediti Baltomor 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 130-62-4472 Months Days Hours Trinidad (Month, Day, Year) 01/14/1953 58 **Director** 1 - M 2XXF 28a-f show 10a. State 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 No 10e. Street and Number 4805 G 10g. Citizen of What Country? Trinidad and Tobago 10f. Zip Code Greencrest Road 21206 Funeral hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. g 1 XNever Married 2 Married 1 Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Black Completed 3 Widowed 4 Divorced Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Cashier Retail event, Be 17. Father's Name (First, Middle, Last)
Rupert Richards 18. Mother's Name (First, Middle, Maiden Sumame) မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zin Code) 4805 Greencrest Road, Baltimore, MD 21206 Nartasha Richards / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 💢 Cremation 3 🗔 Removal from State Atlantic Crematory 11/17/2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Services 21203 21. Signature of Funeral Service Licensee Donota Marshall 23a. Pare 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician) Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, ne Due to (or as a conficuence of) cause. Enter Underlying Examir the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Dav Pregnant at time of death signed by the at Id be detached for g Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of page 2 autopsy performed? Yes 2 No death? certificate 1 Yes 2 No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 🔲 Yes 욘 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred after death. Director: After 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) resident 201 3914 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greenest, Baltimore Mak andice 5, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 2011 Registrar

			1 - For Stete Registrer	St	ate of I	Marylan	•			lealth a Death		ental Hy	giene Reg. No	Z U		37298
3	Physici	ion	Decedent's Name (First, Middle				<u> </u>					2. Date of De Month	ath Da	y Y	'ear	3. Time of Death
	/Medic		Cecil M. Ro									Noveml			011	12:45 PM
	Examir	ner	4a. Facility Name (If not institution			er)		4b. City	Beth	Location (	of Death			County of		*17
- 3		345.07	Maplewood Park  5. Social Security Number	6. Sex		Age (In yrs.	last birthday)	If Unde	r 1 Year	If Under	24 Hrs.	8. Date of Bir		Montg		lace (State or Foreign
	Funeral Director		578-16-5165	1 □ M		90	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Mopth, Da May 17,	1921 <i>(</i>	1	Cour	ington, D.C
	pu ,		Usual Residence of Decedent			100 69	ty, Town or Lo								1	0d. Inside City Limits
	ehov ehov	ò	Maryland Mont	gomery		100. 01	ty, Town or Lo	cation	Po+	hesda						1 Yes 2 No
	28a-f	ect	10e. Street and Number	50mer y				10f. Z	p Code	nesda			10g. Ci	tizen of Wh	at Cour	ntry?
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	s within 72 hours after death with the Maryland ljene. r than "natural", or teme 23a or 28a-f ehow tra Medical Examinar must be notified at	Funeral Directo	11. Marital Status	12. W	/as Decede	ent Ever in U	.S. 13.	Was Dec	edent of H	ispanic Or	igin? (Spe	ecify Yes or No Rican, etc.)	D-	14. Race -	Americ White,	
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	Hys at	BeC	17. Father's Name (First, Middle,	Last)						18. Moth	er's Name	(First, Middle	, Maidei	n Sumame)		
<u>Ja</u>	should be nd Mental marked o	10	Charles G. My	ers,	Sr.							schiffe				
Maryland	2 sh and is m		19a. Informant's Name/Relations		-			-				I Route Numb				
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Baltimore,			4 □Donation 5 □Other (S 21. Signature of Funeral Service				e of H	Name a	nd Addres	ss of Facili	vRobe	ert A.	Pum	phrev	Fun	eral Home/
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68/60,	icate be executed physicien and s the burial-transit	icai	that initiated events ' resulting in death) Last	d	Due to (or	as a consec	quence of):								1	
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DIVISION	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		e. Place of building	Injury - At h , etc. <i>(Speci</i>	ome, farm, st	reet, facto	ry, office			28f. Location City or To			or Rur	al Route Number,
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	To the within 2 To the complet	¥	29b. Signature and title of certifie	r <				2	c. Licens	e number			29d. D	ate signed	(Month,	Day, Year)
			Jay B	will					520	525	8		100,	iembe	- 1	7,2011
_			30. Name and add ss of person		eted cause	of death (Ite	m 23a) (Type,	Print)	in A	he.	#2	11 Se	the	ida	mo	7,2011 20814
	Sta Registi		31. Date filed (Mooth Pay 2ar	2011	32. Reg	istrar's Sig	ture par	per)								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. 20 37299 Certificate of Death 3. Time of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Year Month Physician/ 2011 2:55AM 19 Janet Rogers Redden November Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Rockville Raphae1 Victory House Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Hours 434-42-5846 1 ☐ M 2 💢 F **Director** Louisiana July 30. 85 Usual Residence of Decedent 10d. Inside City Limits ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10a. State Director 1 Yes 2 X No Rockville <u>Maryland</u> Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 20852 7004 Sulky Lane and 2 should be filed within 72 hours after death v Health and Mental Hygiene. Lem 27 is marked other than "natural", or items ther traumatic event, the Medical Examiner mu 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. Yes 2 X No ģ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Own Home Homemaker 4 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Willard Allan Harold Rogers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7004 Sulky Lane Rockville, Maryland 20852 item 27 Harold C. Redden/ Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium Inc. 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot Page 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State November 2011 Bethesda, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Robert A. Rockville, Inc. 300 Wes Rockville, Maryland 208 Pumphrey Funeral Home/ t Montgomery Avenue 50-2805 permit. Signature of Fungral Service Licenses once, Inc. 300 Maryland M00335 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lis Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ <u> Alzheimers Dementia</u> Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical certificate be Box 68760 as IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Day Month Year in the past 12 months?

1 Yes 2 No
9 Unknown Hospital or Attending Physician: The law requires that the death jo Pregnant at time of death been signed by the a should be detached t 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner?
1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Asst. Living 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 27. Manner of Death Certificate: injury 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie November 19, 2011 D37142 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1355 Piccard Drive, #100, Rockville, Maryland 20850 M.D. Geoffrey Coleman, NOV 2 State 2011

DHMH 17 Rev 06-2011

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 02:45A NOVEMBER RAPHAEL Μ. Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner BALTIMORE CITY WEINBERG PARK ASSISTED LIVING Birthplace (State or Foreign Country) 8. Date of Birth . Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours 02/21/1932 217-26-6757 79 Director 1 🗆 M 2 💢 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State **Funeral Director** 1 X Yes 2 No BALTIMORE N/A MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number ò permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a i amy injury or other traumatic event, the Medical Examiner must be once. USA 21215 5833 PARK HEIGHTS AVENUE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. þ 1 Never Married 2 Married Yes 2 X No WHITE Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give 3 Widowed 4 X Divorced Completed Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNKNOWN **HERMAN** ROSE UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3400 ENGLEMEADE ROAD, BALTIMORE, MD 21208 MICHELLE RABINOWITZ/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition SHAAREI TFILOH CEM. 1 X Burial 2 Cremation 3 Removal from State 11/21/2011 BALTIMORE, MD Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEMENTIA yrs Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant Year in the past 12 months?

12 No
9 Unknown Month Day g 🗌 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by unspecified 1 Tes 2 No 3 Probably 4 Unknown Neoplasm Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No 1 🗌 Yes Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSISES INVILLE 2 12 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 - Yes ည 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after deat

To the Funeral Director:
completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and on investigation, in the state of the cause (s) and manner as stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 03037

Registrar

DHMH 17 Rev 06-2011

State

6503

PARK HEIGHTS AVE BALT

38. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. COOPER MD

NOV 22

31. Date filed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 19,201 7:55a November Clifford E. Romenski Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heritage - German Hill Road Baltimore Co. Dundalk Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Hours (Month, Day, Year) 216-30-2298 Usual Residence of Decedent 77 1 🔀 M 2 🗆 F Jan17,1934 Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Director Baltimore City Md. Y Yes 2 No 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21231 U.S.A. 317 South Register Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 XYes 2 No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working ife. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8th Construction Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sophia Prochownik Robert Romenski 19a. Informant's Name/Relationship (Type, PrintNepheW 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3045 Holland Cliffs Rd. Huntingtown, Md20639 William F. Prochownik, 2015 Place of Disposition (Name of Schneter), crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State November Burial 2 Cremation 3 Removal from State 23, 2011Baltimore, Maryland Heart of Jesus 4 ☐ Donation 5 ☐ Other (Specify) M00933 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee Dundalk Avenue Baltimore, MD 21222 201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death disease or condition resulting in death) ACIDENT Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine ER GENSIDH Cause (Disease or injury that initiated events resulting in death) Last OBSTRUCTIVE PULMONARY DISER Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year 4 Pregnant g Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed

burial-transi and attending physician for use as the buria law requires that the death certificate be Division of Vital Records, P.O. Box 68760 been signed by the should be detached cate has I To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certificate: To

**Funeral** 

**Director** 

show

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ms 23a or r must be n

Examiner

Medical

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of Health and Mental H If item 27 is marked ot r other traumatic ever

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Department of Important: If any injury or once.

Ph\_sician/

Medical

**Examiner** 

death

Baltimore, Maryland 21215-0036

1				
			24a. Was an autopsy performed?  1  Yes 2 No 1 Yes 2 No 1 No 1 Yes 2 No	
25. Was case referred to medical		26. Place of Death (Check	only one)	
examiner? 1 🗌 Yes 2 🔼 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	DOA Other: 4 X Nursing Hom	me 5 Residence 6 Other (Specify)	
27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation		work?	28d. Describe how injury occurred	
3 Suicide 6 Could not I 4 Homícide determined		actory, office 2	28f. Location (Street and Number or Rural Route Numb City or Town, State)	er,

1							
ı	29a. Certifier	1 X Certifying Physician: To the best	of my knowledge, death occurred at the tim	e, date and place.	and due to the cause(s)	and manner as stated.	
ı			f examination and/or investigation, in my opini				and manner stated
П	THE RESERVE OF THE PARTY OF THE	or I was seen to be though the contract of the first	All thought of the formal patients of talk transmit fact.	short Harrison Polymer Polymer Polymer	Sear and The to the owner	State on sensence has been	

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

D 27188

11-21-2011

uder KTULKA M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Julka, M.D. 2 Market Place Dundalk, MD 21222 Savinder K.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7302 Reg. No. 2 () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CATHERI 9:00 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore indalk Inverness Hvenue 7. Age (In yrs. last birthday) If Under 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours Min. (Month, Day, 5 **Director** Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗖 No Maryland Dunda Himor e 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral or items 23a 21222 United Inverness within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", Specify: White 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate ainter traumatic event, Be 17. Father's Name (Prst, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Department of Health and Mont. Important: If item 27 is marked any injury or Alter. Rhea Alice ullinger rrank 19a. Informant's Name/Relationship (Type, Pri 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) - Significant Avenup Inverness Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔲 Burial 2 Cremation 3 🔲 Removal from State cemetery, crematory or other place) Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 11-21-2011 sematory retro tion Society of Maryland Inc Baltimore CMD 21228 . Signature of Funeral Service Licer 22. Name and Address of Facility Cremation 299 Frederick Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph. ici. disease or condition Medical resulting in death) Due to (or as a o sequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner sician and burial-transit Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No signed by the atte Month Day Year Pregnant at time of death Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 🗆 No 1 🗌 Yes 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? 2/No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1, Natural injury work? 1 ☐ Yes 5 Pending 4 hours af er death. uneral Director: Afted filled in by the fur 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of completed cause of death (Item 23a) (Type, Rrint) 1245 Eastern Blvd., Baltimore, MD 21221 sad

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ George Schammel Jr. 19 9:15 11 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bel Air Harford 517 Sylview Court 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Hours Director 215-32-2746 1X M 2 D F Maryland 76 10-16-1935 23a or 28a-f show ist be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Harford Maryland Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 517 Sylview Court 21014 must k United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces Black, White, etc. 1 Yes 2 No Completed by 1 Never Married 2 XMarried within 72 hours after Specify: WHITE 1 ☐ Yes 2 XNo Specify: "natural" 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Health Care 12th grade Printer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, George Schammel, Sr. Marie Finnick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health s tem 27 i 517 Sylview Court, Bel Air, Maryland, 21014 Lois Schammel / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s Department of H Important: If ite any injury or ot 1 🗋 Burial 2 💢 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 11-21-2011 Baltimore Maryland Metro Crematory INC 21. Signature of Furieral Service Licensee 22. Name and Address of Facility Cremation Society Of Maryland INC 299 Frederick Road, Baltimo 299 Frederick Road, Baltimore MD 21228 Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner?

1 Yes 2 No Hospital or Attending Physician: Be 26. Place of Death (Check only one) To the Hospiro.

within 24 hours after death.

To the Funeral Director: After this or

"marketely filled in by the funeral dir ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred 5 Pending 2 🗌 No Investigation Acciden
Suicide Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month. 20065827 21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Angela Poppe-Ries, 500 Upper Chesapeake Dr., Bel Air, MD 21014

Registrar

DHMH 17 Rev 06-2011

State

Maryland 21215-0036

Baltimore,

68760

Records,

Division of Vital

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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		Registrar	Certificate (	Di Dealli		Reg. No.	3. Time of Death					
Physic Medical Exan		er Jack Barnett Staton November 18, 2011										
		4a. Facility Name (if not institution, give street and number) 199 Plymouth Lane Apt. A		4b. City, Town, or Location Glen Burnie	n of Death	4c. County of Dear						
Funera		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year If Un Months Days Hou		Birth(MM/DD/YYYY) 9. Bi						
Directo		212-84-7510 1 M 2 F Usual Residence of Decedent	49 Y		Dec 2	21, 1961 °	ountry)Maryland					
v any			City, Town or Loc	ation			10d. Inside City Limits					
Maryland 28a-f show	ģ	Maryland Anne Arundel	Glen	Burnie			1 Yes 2 No					
he Mar or 28a	Director	10e. Street and Number  199 Plymouth Lane Apt. A		10f. Zip Code 21061		10g. Citizen of What Cou	intry?					
death with the Maryland or items 23s or 28s-f she	uneral	11. Marital Status 12. Was Decedent Ever		/as Decedent of Hispanic O			rican Indian, Black,					
by MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other fram "matural", or items 23a or 28a-fabs fraumatic event, the Medical Examiner must be notified at once	,, -	1   Never Married   2   Married   Armed Forces?   1   Yes   2   X	No	Yes, specify Cuban, Mexical Yes 2 X No specif		White, etc.  Specify: Whi	to					
tours af	od be	or Dates:  15. Decedent's Education (Specify only highest grade complete	ed) 16a. Decede	ent's Usual Occupation (Give	e kind of work done	16b. Kind of Business						
5-0036 led within 72 hours : Hygiene. other than "natura the Medical Exami	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		most of working life. DO NO Spenter	Tuse retired)	Construc	tion					
5-00 ed with fygienc other it	E	17. Father's Name (First, Middle, Last)		-	er's Name (First, Middle,							
AD 21215-0036 2 should be filed within 7 1 and Mental Hygiene. 27 is marked other than matic event, the Medican	o Be	Jack Barnett Staton  19a. Informant's Name/Relationship (Type, Print)	100 11 10		race King							
nore, MD 2121 ages I and 2 should be fi nt of Health and Mental I tt If item 27 is marked other traumatic even,	ř	Edith Staton, Sister	V.0	ng Address (Street and Nu Gemini Drive								
re, ML s: l and 2 s of Health ar If item 27				sition (Name of cemetery,	Date	20c. Location - City or						
E 4 9 5 5		4 Donation 5 Other Specify:	Metro Cre	ematory Inc.	11/22/11	Baltimore	, Maryland					
Balti permit. Departm Imports		21. Signature of Funeral Service Licensee Thomas Gre	egor (2)	Name and Address of Facil emation Soci 9 Frederick	ety Of Mary Road Baltin	land, Inc.	nd 21228					
Physician /Medica		failure. List only one cause on each line.										
Examine		Immediate Cause (Final disease or condition resulting in death)  a. Diabetic Ketoacidosis  Due to (or as a consequence of):										
	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Diabetes Me										
	Examiner	cause Enter Underlying Couse (Disease or injury that initiated										
ecuted and - transit		events resulting in death) Last Due to (or as a consequent d.	ice of):									
ian ial	n/Medical	▼ UNPENDED □ AMENDED 23a-b	,27,per 1	ne,g922 12-2-	11 sm							
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of 1 Live birth	pregnancy 2 F	etal death 3 Ectop	ic pregnancy	23d. Date of deliver	y Day Year					
Box 687 ie death certific the attending I	Physicia	1 Yes 2 No 9 Unknown 9 Unknown	of death	other (Specify)								
C = 5 5	0-	Part II. Other significant conditions contributing to death but in	not resulting in the	underlying cause given in P		obacco use contribute to						
ls, P.( quires tha en signed	ted by			<del></del> -		s 2 No 3 Prot						
of Vital Records, og Physician: The law requinter this certificate has been sineral director, page 2 should the nest director, page 2 should the state of the sta	Completed				24a. Was auto perfo		topsy findings available completion of cause of					
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Vita hysicia this ce	To Be	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2	ER/Outpatien			Residence 6 🗸 Other	: Scene					
⊏ਚੀਂੂੈਵੀ		27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day, Year)	28b. Time of	Injury 28c. Injury at Wor	į.	how injury occurred	-					
Division tal or Attendians after death.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury -	At home, farm, stre	et, factory, office building, e	etc. 28f. Location (	Street and Number or Ru	ral Route Number, City					
15 G P		4 Homicide determined (Specify)			or Town, §							
Divisio  To the Hospital or Attenwithin 24 hours after deal To the Funeral Director:	Medical	(Check only one) 1 Certifying Physician: To the best of my know one) 2 Medical Examiner: On the basis of examination and manner stated.										
	×	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mor						
John bound		30. Name and address of person who completed cause of death (	Item 22a)	O.C.M.E.		November 19, 20	)11					
o p		Russell Alexander MD. Assistant Medical Ex		W. Baltimore Street,	Baltimore, MD 21	223						
S Regis	tate trar	31. Date filed (Month, Pay Year) 32. Registrar's Sig	nature Save	9		anue.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ James E Span, Sr. 2011 12:40 PM 16 Medical November 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's 2615 Newglen Avenue District Heights Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 M 2 F Hours 261-58-8372 Director 73 Florida Yrs April 1938 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy njury or other traumatic event, the Medical Examiner must be notified once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Prince George's District Heights 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2615 Newglen Avenue 20747 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Black. Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Community Housing Educator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Barnie Span Palace Byrd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Span - Wife 2615 Newglen Avenue District Heights, MD 20747 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Galilee Cemetery 11-21-2011 4 ☐ Donation 5 ☐ Other (Specify) Sarasota, FL Signature of Funeral Service Licenses Chandlers Funeral Chapel 22. Name and Address of Facility 1425 Dr. Martin Luther King Jr Way Sarastoa, FL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Between mediate Cause (Final Onset and Death Metastatic Colon Cancer Physician. disease or condition 6years Medical resulting in death) Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence or) nding physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death
Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed een 24b. Were autopsy findings available prior to completion of cause of 24a. Was an filled in by the funeral director, pcge 2 autopsv performed? ☐ Yes 2 🖾 No death? 1 Yes 2 No 25. Was case referred to medica æ 26. Place of Death (Check only one) examiner? 2 🔁 No 1 🗌 Yes Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 M Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural
2 Accident
3 Suicide 28d. Describe how injury occurred 5 Pending injury work? 2 No Investigation 6 Could not be

Division of Vital Fecords, P.O. Box 68760 To the Hospital or Attending Physician: Director: After this within 24 hours after or To the Funeral Direct

29d. Date signed (Month, Day, Year) Williams, D.O. H0058032 Nov. 17, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia Williams, MD 3720 Upton St. NW Washington, DC 20016 31. Date filed (Month, Day, Year, 82. Registrar's Signature State NOV 2 2

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

MDHMH 17 Rev 7/2009

Registrar

4 Homicide

3 🗆

29b. Signature and title of certifier

29a. Certifier (Check

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Harry R. Sanford 18, 2011 12:28 AM November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Hours 220-36-8040 Director 1**X**] M 2 □ F 70 August 25,1941 Baltimore, Maryland Usual Residence of Decede 28a-f show 10c. City, Town or Location notified at 10a. State 10d. Inside City Limits Director Maryland Baltimore Cockeysville 1 Tes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 13 Waterbird Court 21030 United States items? oe filed within ...
fental Hygiene.
arked other than "natural", or items
"ent, the Medical Examiner m 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2XXMarried þ 1 ☐ Yes 22 If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Systems Analyst Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be file alth and Mental H 27 is marked o permit. Page 1 and 2 should be f Department of Health and Mental Important; If item 27 is marked any injury or other traumatic ev ျ Florence Levering Harry R. Sanford, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 Waterbird Court, Cockeysville, Maryland 21030 Joan Sanford (Spouse) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State November 23, Evans Funeral Chapel-Hel Forest Hill, Maryland 4 Donation 5 Other (Specify) Signature of Juneral Service Licensee Name and Address of Facility
Evans Funeral Chapel & Cremation Services—Parkville
8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one passe on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ omplication disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami and Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be P.O. Box 68760 the attending | for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Dav Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1XYes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Tyes 2 No Other: HOSDICE မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) I hours after death.

uneral Director: After the filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1XX Natural 5  $\square$  Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital within 24 hours a To the Funeral C completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu 29d. Date signed (Month, Day, Year) 78211000 11-18-11 Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Ste 4105, Balthwere, MD 21204

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State

Registrar

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Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Frederick W. Severn 11-17-2011 20:07 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1844 Pulaski Highway Unit 22 Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year 06/21/1961 9. Birthplace (State or Foreign Country) MaryLand 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days Min 1 M 2 □ F 50 219-72-7647 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'te Medical Examiner must be rediffied at once. 1 X Yes 2 □ No Maryland | Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1844 Pulaski Highway Unit 22 21078 United States of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u>ک</u> Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Home Improvement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward W. Severn, Sr. Betty J. Singleton ပ 19a. Informant's Name/Relationship (Type. Print) Teresa Bradley (sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33191 Horsey Church Road, Laurel, Delaware 19956 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baker Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/22/2011 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, P.A. 21078 mutu of Funeral Service Licensee 123 S. Washington St., Havre de Grace, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** and i various disease Gaqueritally flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consed) ence of): Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran MOHAC resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 N Residence 6 Other (Specify) Hospital: 1 Yes 2 ₩0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29b. Signature and title of c 29c. License number 29d. Date signed (Month, Day, Year) 11/21/11 JO8 215 que, bounde gree, ped 21078 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 601. MD 5 UMION 31. Date filed (Month, Day, Year) NOV 2 2 2011 32. Registrar's Signature State Registra

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	,	For		State of	f Marylar	nd / Dep	artmer	nt of H	lealth a	and N	1ental Hy	gien		1	27	200
	7	State Registrar	# 1 == 4\			Ce	ertificat	e of L	Death			Reg. N	10. 20		31	308
Physician/ Medical	L	. Decedent's Name (First, Mid SOPHIE					STEI	N			2. Date of De Month		Day Ye 201	ar 1	3. Time of 0	
Examiner	4	a. Facility Name (if not institut			,		1	, , ,	Location of			4	lc. County of [			
Funeral	5	SEASONS HOS Social Security Number	PICE 6. Sex		THWEST 7. Age (In yrs.			er 1 Year	ALLST		8. Date of Bi	-th		_	IORE lace (State or	Foreian
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traum	ľ	9a. Informant's Name/Relatio  JOYCE GORDON					-				I Route Numbe				,	
other	2	Da. Method of Disposition	·			Place of Disp	osition (Na	me of			Date	_	Location - Cit			
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any inju	2	Signature of Funeral Service		е			KURI 22. Name ar	nd Addres	ss of Facility		LEVIN					
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/Me	-	FEMALE:	20	3c. If yes, outc	ome of progn	angu										
should be detached for use as leted by Physician/Me	2	3b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	20	1 Live E	lirth 2 🗀 Fet ant at time of	al death 3	☐ Ectopic ☐ Other (s)	pregnanc pec <i>ify)</i>	·y				23d. Date o Month		ry Day Ye	ar
by PI	P	art II. Other significant cond	tions con	tributing to de	ath but not re	sulting in the	underlying	cause giv	en in Part I		23e. Did 1	obacco	use contribut	e to the	e cause of de	ath?
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<u>=</u>  =		7. Manner of Death	ding	28a. Date o	npatient 2 f injury n, Day, Year)	ER/Outpati 28b. Time injury		28c. Injury work	4		me 5 Resi 28d. Describe			pecify)	700	<b>J</b>
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Medical	2	(Check 2 Medica	l Examine	er: On the basis	s of examination	n and/or inve	stigation, in	my opinio	n. death oc	curred at	nd due to the c	and plac	ce and due to	the cau	se(s) and man	ner stated.
omple	2	only one), 3 Certifyi	ng Nurse	Practitioner:	To the best of	my knowledg	e, death occ	curred at the	he time, dat	e and pla	ce, and due to	the caus	se(s) and mann	er as s	tated.	
5	<	Then II	with	(M)			/	2004	337	4-		111	/ - /	20 /		
	3	). Name and address of person HALLON W. MEN	n who cor	mpleted cause	of death (Item	1230 (Type,	Print) Su	it 2	103 (	Balt	mine,	hi,	"			
State	3	. Date filed (Month, Day, Year	_	32. R	gistrar's Signa	ture	back	1								
Registrar		NOV	2 2 20	111 /	new	P. G	200									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Eric John Super 20, 2011 November 11:44 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 763 Generals Highway Millersville Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral Director** 219-90-7239 1 X M 2 🗆 F 52 September 30,1959 Maryland Usual Residence of Decede or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Millersville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code must be r 10g. Citizen of What Country? Funeral 763 Generals Highway 21108 United States er than "natural", or items the Medical Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. ed Forces? Black, White, etc. 1 X Yes 2 No 1980—
If Yes, Give
Year or Dates. 198 þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White 1984 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Home Improvement Contractor Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of ဂ Richard Super other traumatic Mary Ann Dowd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or Attach Leslie P. Super/Wife 763 Generals Highway, Millersville, Maryland 21108 Baltimore, 20b. Place of Disposition (Name of West Arunde 1 other place)
Crematory 20a. Method of Disposition 20c. Location - City or Town, State November 22, 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2011 Odenton, Maryland Signature of Funeral Service Licensee Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road, Odenton, Maryland 21113 Will Expones M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Previous/ disease or condition Metastatic Head and Neck Cancer - Tongue 2-Years Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examir and -tran resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Phystcian: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death Day Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 X No Other: 1 Yes မ 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🗶 Natural 5 Pending iniury 1 Yes 2 No Accident Investigation 6 Could not be 2 Accider
3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Registrar DHMH 17 Rev 06-2011 only one)

Nicholas W.

29b. Signature and title of certifier

WINNINS

Kowflela

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Koutrelakos,

MI

M.D.,

32. Registr 's Sign

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D38509

29d. Date signed (Month, Day, Year)

11-21-11

10710 Charter Drive, Suite G020, Columbia, MD 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 6:39 P.M. M Irene M. Swing Nov 19 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 4954 Chestnut Street Shady Side Anne Arundel 5. Social Security Number 577 20 5207 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Sex 1 M 2 X 96 Months Days Hours Min. Yrs Washington DC **Director** 1915 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 3a or 28a-f sh t be notified a 1 Yes 2X No Anne Arundel Shady Side Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4954 Chestnut United States Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TXNo Specify: Specify: White Completed 3XXWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Accounting Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Celeste Laura Watson John (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7003 Nimitz Drive, Forestville, MD 20747 Margurite Mason (Daughter) or other 20a. Method of Disposition
1 ☐ Burial 2 【ACremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of h Important: If ite any injury or ot Nov 22, 2011 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral Service Licensee Ferry Road, Clinton, MD 20735 M00257 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Errier Unioerlying Cause (Disease or iinjury Due to (or as a conser unice of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 X No Day Pregnant at time of death Unknown 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 XXResidence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No. Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined within 24 hours a

To the Funeral D Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

arven

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6131

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Day Month 4.30 AM Joan Catherine Sites 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death WASH AMNE ARUNIDER CEMTER G L -574 BURHIE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 D Months Hours Min. July 6 1944 218 48 5153 Director 67 Baltimore, Maryland Usual Residence of Decedent 28a-f show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Me 1 al Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Anne Arundel County 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 17 A MapleDale Avenue 21061 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Housekeeping-Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 John Huber Gertrude Fischer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James T Sites (Husband) 17 A Maple Dale Avenue Glen Burnie, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Holly Hills Memorial Gdns. November 25 2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 21 Signature of Funeral Service Licensee Lassann Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final Physician/ NEUMONA AYG disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner OBSI MUTTINE MRONILL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events 1 FARS UNG and Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical P.O. Box 68760 nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Day Pregnant at time of death ed by the Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has 2 🗆 No 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 욘 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ☐ Natural 5 Pending injury o 24 hours after death.

Funeral Director: Aft leted filled in by the fur 1 Yes 2 No Investigation
6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) Medical Secretifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie сопріеть (Check Within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

TEPRUE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BATTER

Bonnie

32. Registrar's Signature

00059190

301 HOSPITAL DR

29d. Date signed (Month. Day. Year)

ELEN BURNE

14 CV 21 2011

			Please I	<b>ype or Print in Black</b> State of Maryland / De				_	е.
			For State Registrar		Certificate of L		мена пу	Reg. No. 201	1 37312
	Physicia Medic	al	1. Decedent's Name (First, Middle, Last)	Jane Roberts St	ern		2. Date of De Month Novemb	eath	3. Time of Death 11:15 PM
	Examir	er	4a. Facility Name (if not institution, give sti 5 Gardenway, Unit	reet and number) K	4b. City, Town, o Gree	r Location of Deatl nbelt	n	4c. County of De Prince	George's
	Funeral Director		5. Social Security Number 212-36-8253  0 Sex 1 Usual Residence of Decedent	M 2 $\sqrt{100}$ F 7. Age (In yrs. last birtha	Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir 10/03/	th 9. E	Birthplace (State or Foreign Country) MD
	Maryland 8a-f show tified at	rector	10a. State MD Prince	George's		enbelt			10d. Inside City Limits 1 ☒ Yes 2 ☐ No
	with the I is 23a or 2 nust be no	Funeral Director	10e. Street and Number 5 Gardenway, Un	it K	10f. Zip Code	20770		10g, Citizen of What (	Country? USA
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	۵	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	<ul><li>13. Was Decedent of H If Yes, specify Cuba</li><li>1 ☐ Yes 2 ☐ No</li></ul>	an, Mexican, Puert	oecify Yes or No- o Rican, etc.)	14. Race - An Black, Wh Specify: W	
215-(	n 72 hou e. ian "nat Medica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)		ecedent's Usual Occup Give kind of work done of Fe. DO NOT use retired)	ation during most of wor	king	16b. Kind of Busines	ss Industry
d 21	ed with Hygien other th	Be Cc	12 17. Father's Name (First, Middle, Last)	5+	Teacher	40 Mathaula Na	(Fine A & C. 1)	Educati	on
ylan	ld be file Mental arked c	욘	Simpson Rober	^ts		Mild:	, , ,	Maiden Surname) Wart	
Baltimore, Maryland 21215-0036	and 2 shou Health and em 27 is m ther traum		19a. Informant's Name/Relationship (Type Susan Stern / Dau	ughter 5	Mailing Address (Street Gardenway,	unit K,	Greenbe	r City or Town, State 1t, MD 207	Zip Code) 70
Itimore	it. Page 1 autment of Hartant: If ite		20a. Method of Disposition  1 ☐ Burial 2 【 Cremation 3 ☐ R.  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Chesape	hisposition (Name of crematory or other place ake crematory	ory 11/	Date 23/2011	Beltsvil	le, MD
Ba	perm Depa Impo any i		21. Signature of Funeral Service Licenses	. learshall	22. Name and Addre Mar	ss of Facility y l and Cre nBox 141.	emation 3. Balti	Services more, MD 2	1203
Į	Physician/ Medical		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Do not cause on each line. Glioblastoma M  Due to (or as a consequence of):	enter the mode of dyin ultiforme	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death Ued Y
	Examiner	e.	Sequentially list conditions, b.						
8	executed an and rial-transit	Examiner	if any, leading to immediate cause. Error Underlying Cause (Disease or iinjury that initiated events	Due to (or as a consequence of):					
09,		ल	resulting in death) Last	Due to (or as a consequence of):					
. Box 68760	ne death certificate be the attending physici ched for use as the bu	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	c. If yes, outcome of pregnancy  1  Live Birth 2  Fetal death 4  Pregnant at time of death 9  Unknown	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	гу		23d. Date of o	delivery Day Year
, P.O	law requires that the des nas been signed by the a s 2 should be detached f	by PI	Part II. Other significant conditions cont	ributing to death but not resulting in t	he underlying cause giv	ven in Part I.	1	obacco use contribute	
ords	requ been shoul	oleted					1 🗆		Probably 4 Unknown
Rec	0 0	Completed					auto	rmed? death?	autopsy findings available o completion of cause of? Yes 2  No
/ital	sician; The s certificate lirector, pag	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	spital:	Oth	ace of Death (Che			
of	ing Phy fter this ineral d	ate: T	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	1 ☐ Inpatient 2 ☐ ER/Outp  28a. Date of injury (Month, Day, Year)  1 ☐ Inpatient 2 ☐ ER/Outp  28b. Tim inju	atient 3 LI DOA 28c. Injur	4 □ Nursing F y at	1	dence 6 Other (Spenow injury occurred	ecify)
Division of Vital Records,	or Attendi after death Director: A in by the fi	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	M 1 🗆	Yes 2 No	28f. Location (S City or Tov	Street and Number or F vn, State)	Rural Route Number,
Q	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate completed filled in by the funeral director, pa	Medical	(Check 2 ☐ Medical Examine	an: To the best of my knowledge, de	nvestigation, in my opinio	on, death occurred	at the time, date a	and place, and due to the	e cause(s) and manner stated.
	To the within To the comple		only one) 3 Certifying Nurse I	Practioner: To the best of my knowled	29c. License			e cause(s) and manner a 29d. Date signed (Mor November	
	11		30. Name and address of person who con Matilda H. So,		e, Print) Jpper	Marlbor	o, MD 20	)774	
	Stat	е	31. Date filed (Month, Day, Year)	32. Registrar Signature	V				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Eileen Ellen Stiltner Physician/ November 17, 2011 1:44 R Medical Facility Name (if not institution, give street and number)
Stella Maris Hospice 4b. City, Town, or Location of Death 4c. County of Death
Baltimore **Examiner** Timonium 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 MD Social Security Number 213-30-1340 **Funeral Director** 80 05/10/1931 1 🗆 M 2 🗓 F Yrs 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director notified MD Baltimore · 28a-f 1 ¥ Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō must be Funeral Dahlia Lane 21220 items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner r 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 X No Yes Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 🗶 No Specify: Completed 3 Widowed 4 X Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry e 1 and 2 should be filed within 72 to f Health and Mental Hygiene.
If item 27 is marked other than "nor other traumatic event, the Medi (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manager Transportatiónn Be 17. Father's Name (First, Middle, Last)
Charles Coursey 18. Mother's Name (First, Middle, Maiden Surname) ၉ Carroll Ida 19a. Informant's Name/Relationship (Type, Print)
Carol Levin / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 Maro Road, Pasadena, MD 21122 permit. Page 1 and 2 Department of Healti Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Chesapeakce Crematory 1 Burial 2 X Cremation 3 Removal from State 11/19/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility remation Services 21203 PO BOX 1413, Baltimore, MD 21203 Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) 1515 the attending physician and Due to (br as a consequence of): resulting in death) Last n 47, ecords, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 wonths?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? this certificate ☐ Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Natural 28c. Injury at 28d. Describe how injury Director: After work? 5 Pending Accident Investigation Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of cert 29c. License numbe 29d. Date signed son who completed cause death (Item 23a) (Type, 30. Name and address of Print) 23 IO 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Alan Shaw Day Physician/ Month 10:45P<sup>M</sup> November 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 106 Felton Road Lutherville Baltimore Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Hours 1 X M 2 D F Min. (Month, Day, Year) 03/22/1957 New Jersey Director 264-11-5978 54 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 106 Felton Road U.S.A. death v 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) o Black White etc. þ 1 Never Married 2 Married Jid be filed within '...

Mental Hygiene.

Mertaral'', o Yes, Give Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: 3 ☒ Widowed 4 ☐ Divorced Completed Specify: Year or Dates White injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Auditor Defense marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ပ Laurence Caroline Jean Griffith 1 and 2 should by Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William L. Shaw / Son 106 Felton Road, Lutherville, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 11/21/2011 Anatomy Gifts Registry Hanover, Maryland 21. Signature / Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 etastatic Physician rastroesophagea disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, If any, leading to minediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burial physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown 2 No 9 I Ilnknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 从 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page performa 1 Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2/10 Other: 1 🗌 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No after death. Investigation 3 Sulcide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Funeral I Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of co 29d. Datersigned (Month, Day, Year) 11/21/11 Acoldgis7 ጎ٥ 10W30n Charles St 656 110011 32. Registrar's Sig State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 28f per me 9921 11/21/2011 dbb 196 per fibre State of Maryland Department of Health and Mental Hyglene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month CARROLL SHILLER NOVEMBER 2011 11:25P 4a. Facility Name (if not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death SUMMIT PARK HEALTH & REHAB CATONSVILLE BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. Birthplace (State or Foreign Country) 6. Sex. 1 ⚠ M 2 ☐ F 7. Age (In yrs. last birthday) 8. Dete of Birth Euneral Months Director 217-07-0578 92 MD Usual Residence of Decedent 28a-f show 27 Is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 ី No HOWARD ELLICOTT CITY 10e. Street end Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 8720 RIDGE ROAD 21043 USA death 12. Wes Decedent Ever in U.S. Armed Forces?
1 ⚠ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, \$ 1 Never Married 2 Married Bleck, White, etc. within 72 hours after 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Midowed 4 ☐ Divorced Completed Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only high id 2 should be filed within 72 leath and Mental Hygiene, n 27 ls marked other than "; grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 BUSINESS OWNER FURNITURE & APPLIANCES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 SHILLER **ESTHER** LONDON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 7826 1 and 2 s f Health a DAVID SHILLER / BROTHER HOLLOW LANE, ELLICOTT CITY, MD 21043 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cernetery, cremetory or other place, permit. Page 1 a Department of H Important: If ite any injury or ot 20c. Locetion - City or Town, Stete Date 1 🖾 Burial 2 🗆 Cremetion 3 🗆 Removal from State LOUDON PARK 4 Donation 5 Other (Specify) 11/16/2011 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. mais le 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Finel Onset and Death te mus diseese or condition resulting in death) rvac Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause Enter Industry Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the pest 12 months? 5 Other (specify) Month Dav Year 1 Yes 2 No sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by e Candiovascular 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform performed? this certificate 1 Yes 2 No r: After this certifica e funeral director, p Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
Yes Hospital 2 🗆 No Other 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work?
1 Yes 2 No Director: A 09/28/2011 Kinciel 01 Investigation un 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5755 Cedar Lane, Columbia, MD Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined To the Hospital within 24 hours a To the Funeral C completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Prectioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 18667 November 14, 2011 who completed cause of death (Item 23a) (Type, Print) 11 Citytherville, Mdziog3 Trumbl 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Rosaline E. Sandi State of Maryland / Department of Health and Mental Hygiene 2011 37316 1- For State Certificate of Death Registrar 1 Decedent's Name (First, Middle Last) 2. Date of Death Physician/ Month Day November 11, 2011 **Medical Examiner** 2204 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death FutureCare Nursing and Rehab Clinton Prince George's 9. Birthplace (State or Foreign 5.2 (CA 5 Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) **Funeral** 6 Sex 7. Age (In vrs. last birthday) Director 23 Country) 2**X** F 1 M Usual Residence of Deceden 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 No 28a-f show WDPages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.
nnt: If item 27 is marked other than "natural", or items 23s or 28s.f. sho. Prince Director 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 735 0 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specity Yes or No-Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes Yes, Give Year or Dates: 4 Divorced 1 Yes 2 No specify: Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industr Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be MAKIAMA onteh 19a. Informant's Na e/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, tate, Zip Code) lina . Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee Street Grune 8 AMARAS 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he failure. List only one cause on each line. Hypertensive Cardiovascular Disease complicated Approximate Interval Physician Between Onset and /Medical Immediate Cause (Final disease a by bilateral femur fractures Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to for as a consequence of: Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical attending physician or use as the burial X UNPENDED AMENDED 23a, pt.II, 27, 28a-f, per me, g922 12-15-11 sm Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the past 12 months? Live birth Fetal death 3 Ectopic pregnancy Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ã 1 Yes 2 No 3 Probably 4 V Unknown Renal Disease; Dementia Completed After this certificate has been a 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed page 1 ✓ Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗹 Other: Scene ER/Outpatient 3 DOA 1 Yes 28d, Describe how injury occurred 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? Certification: To the number after death.

To the Funeral Director: A 1 Natural 5 Pending 1 Yes 2 X No fd 11-9-11 2 X Accident fd 7:45 am 28f. Location (Street and Number or Rural Route Number, City or Town, State) 9106 Pineview Ln. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be determined (Specify) Nursing Home Homicide Clinton.Md 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 16, 2011 du 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol Allan, MD strar's S State Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 1:50 AM Ning Guang Shi 2011 DIEMOGR Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Sinai Hospital Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 119-78-5400 **Director** 1 XM 2 🗆 F 53 May 30, 1958 China Yrs Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD Howard Ellicott City 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4055 Old Columbia Pike 21043 China 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 X Married within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Asian Pacific Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry I Hygiene. other than " life. DO NOT use retired) Elementary/Secondary (0-12) 8th College (1-4 or 5+) Chef Private and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Guo Dong Shi Meiying Li 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annie Lin (Wife) 4055 Old Columbia Pike, Ellicott City, MD 21043 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ardent Cremation 11/21/2011 Hanover, MD 22. Name and Address of Facility Latimore Funeral Services, PA almor 2818 E. Baltimore Street, Baltimore MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition iVER CANCER Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Thinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 has 2 No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospi CE Hospital Other: 1 Yes 2 1 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Dother (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director; 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signatur and title of certifie 29d. Date signed (Month, Day, Year) D7033 November 21, 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Liunzhon 1401 west belvedere ave, Baltimore, MD 21215

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year

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32. Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 20, 2011 2:29 Schwab November PM John Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Stella Maris Hospice Center Towson Baltimore 5. Social Security 2007 If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Y April 21, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** <sup>Year)</sup> - 1920 Months Days Hours 302-24-3<del>483</del> **Director** 1 🛣 M 2 🗆 F 91 Ohio 28a-f shov 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Maryland Dundalk Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 7412 School Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠Yes 2 ☐ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: "natural" Completed 3 X Widowed 4 □ Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Post Office Letter Carrier 8 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John Schwab Ida Ellen Eckert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a my ortant: If item 27 is any injury or other tra John Raymond Schwab son 6101 Walther Avenue, Baltimore, Maryland 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Noveliber 1 🗌 Burial 2 🔀 remation 3 🗆 Removal from State 25, 2011 BAltimore, Maryland Bavview Creamtory 4 ☐ Donaţion 5 ☐ Other (Specify) o Funeral Service ignaturi Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Maryland 21222 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical consequence Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical John John Fvital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No signed by the atte d be detached for 5 Other (specify) Month Pregnant at time of death Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Yes 2 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗆 🗸 Hospital Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pendina 1 Yes 2 No Accident Investigation M 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and 29c. License number person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month 4:00 4 Arthur S. Sheely 2011 Medical 4a. facility Name (if not institution, give street and number) an of Death 4c. unty of Death **Examiner** ashimter Medical nne Urni Security Number 6. Sex **J** 1 M 2 □ F Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 12/19/1919 91 PA. 177 16 1979 Director Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at rector 28a-f Maryland Anne Arundel Baltimore 1 Yes 2 X No ā 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 4205 -3rd Street 21225 U.S. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give WW T Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò δ 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after altimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: "natural" Completed 3 Widowed 4 Divorced WW II Year or Dates. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Tax Auditor I.R.S. years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Arthur Chester Sheely Pluvia Applemann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladys Sheely / Wife 4205 - 3rd Street Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 11/25/2011 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. Signature of Funeral Service Licensee Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part 1. Enter the disease, or amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List set and Deal Immediate Cause (Final Physician/ 160 more disease or condition resulting In death) Medical **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical **B**ox 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ neral Director; After this certificate has been signed by the atte filled in by the funeral director, page 2 should be detached for r in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 9 Hospital or Attending Physician: The law 24 hours after death.
Funeral Director: After this certificate has ' autopsy performed 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 4 10 မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manne of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work? 1 □ Yes 2 □ No. Investigation M Accident Suicide Could not be 3 ☐ Suiciae 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fil 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi Registr State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 19 2011 4:00 PM Ann C. Stephens Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 15 E. Ridgely Road Lutherville Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 12-01-1927 **Funeral** 9. Birthplace (State or Foreign Months 135-20-0943 **Director** 1 □ M 2 🔀 F 83 Yrs. New Jersey Usual Residence of Decede 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 205 E. Joppa Road 21286 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Completed 3 Widowed 4 Divorced Specify White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Computer programming Banking is marked other aumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Florence McMullen William Stephens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie A. Doster/ Niece 15 E. Ridgley Rd. Timonium, MD. 21093 Department of Health Important: If item 2: any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 
Burial 2 
Cremation 3 
Removal from State Hilltop Service Co. 11-22-11 Towson, MD. 4 ☐ Donation 🏂 ☐ Other (Specify) 21. Signature of F eral Se 1050 York Road 22. Name and Address of Facility ice Licensee Ruck Towson Funeral Home, Inc. Towson, MD 21204 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and burial-tra Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 month Day Year be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 death? Director: After this certificate 2 🗌 No 1 Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this continuations. funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? PIECE. 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Letner (Specify, 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 V Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER Day 6 2011 5:10 pM Physician/ William Susie, Jr. Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** TOWSON BALTIMORE GREATER BALTIMORE MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours March <sup>D</sup>31<sup>Yea</sup>1955 Marvland 218-68-5010 56 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location at Director ms 23a or 28a-f s must be notified 1 Yes 2 No Baltimore Timonium Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21093 U.S.A. 2127 Suburban Greens Drive permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mentai Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner musonce. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 N Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Defense Industry System Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Swinson William Susie, Sr. Alma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 2127 Suburban Greens Drive Timonium, Maryland Paul B. Susie Brother 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 11-21-2011 | Baltimore, Maryland 4 Donation 5 Other (Specify) Oak Lawn Cemetery 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Sign 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) - Klebsiella, VRF Examiner evenua Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events -transit the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Jun normals after death.

I Director: After this certificate has been significate after the properties of 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural
2 Accident
3 Suicide 5 Pending work?
1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Small MD 0005734 11/17/2011 Curtua 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 670; N. Challes St Baltimire MD 21204 Cynthia Joriano Mo

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) --

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37322 State
Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ZO 11 Month Shereshers Knya 4:00AM Khaya Physician/ November Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Hours Min. 1 ... M 2 X F 218-37-4272 Director 12/15/1919 BELARUS 91 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10b. County 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 🗌 Yes 2 ី No BALTIMORE PIKESVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21208 7 SUDBROOK LANE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No Specify: Maryland 21215-0036 WHITE 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) EDUCATION ELEMENTARY SCHOOL TEACHER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ith and Mental H 27 is marked of traumatic even မ UNKNOWN UNKNOWN UNKNOWN UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ont of Health a 307 WYNDHAM CIRCLE, #1, OWINGS MILLS, MD 21117 EDUARD SHERSHEVSKIY / SON Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Department of Important; If any injury or once, CHEVRA AHAVAS CHESED 11/20/2011 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter of disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final End-Stage Demention Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?

1 Yes 2 No
9 Unknown Live Birth 2 ☐ Fetal deat
 Pregnant at time of death Day P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical 4 Nursing Home 5 Residence 6 Other (Specify) Other: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Medical Certificate: 1 Natural 5 Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At completely filled in by the fu Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certifier

WS RUMP (1991) D0057465

State Registrar M

2835 SMIM

32. Registrar's Signature

5703

Baltimore

MD 51209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S. Rajapa Kse, M.D

31. Date filed (Month, Day,

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar		Cert	tificate of D	eath		Reg. No.	. U I I	3/323
Physician/			1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month Day Ye						Year	3. Time of Death 7:14 Р м	
Medic		al .	Charles Maynard Stetler  a. Facility Name (if not institution, give street and number)			No.					
	Examin	er	4a. Facility Name (if not institution, give site)		4b. City, Town, or Location of Death  Bel Air  Harford						
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	1	9. Birth	place (State or Foreign Sylvania
	Director		211-26-2876 Usual Residence of Decedent	77	Yrs.			Apr. 3,	1934	Penn	Sylvania
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ro	10a. State 10b. County	10c. City,	Town or Loc	ation					10d. Inside City Limits
		irec	Maryland Harford	Bel	Air_						1 Yes 2 No
		Funeral Director	10e. Street and Number  2447 Conowingo Ro	had.		10f. Zip Code 2101	5		10g. Citizen USA	of What Cou	intry?
		-une		Was Decedent Ever in U.S.	13. W	Vas Decedent of His Yes, specify Cubar		pecify Yes or No-		Race - Americ	
		þ	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 X Yes 2 No If Yes, Give Year or Dates.	- 1	Yes 2 No		Tricari, etc.,	Spec	Black, White, cify: <b>Wh</b>	nite
2-0		plet	15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working			king	16b. Kind o	f Business In	ndustry
12		Completed	Elementary/Seconday (0-12) College (1-4 or 5+)		life. DO NOT use retired) Pastor				Religion		
פֿ	filed wall Hyging I othe	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,		ame)	
ylaı	permit. Page 1 and 2 should be Department of Health and Ment! Important: If item 27 is market any injury or other traumatic once.	To	Charles (nmm) Stet					enieve Pi		A 7:	
Ma			19a. Informant's Name/Relationship (Type, Sadie Stetler / Wi:	· .	19b. Mailin <b>2447</b>	g Address (Street a	nd Number or Ru Jo Road,	Bel Air	, MD 2	1, State, Zip	Code)
re,			20a. Method of Disposition	20b. Pla	ce of Dispos	sition (Name of	e)	Date	20c. Location	on - City or T	
imo			4 Donation 5 Other (Specify) Bel			Air Memorial Gdn 11-23-20  22. Name and Address of Facility McComas				11 Bel Air, Maryland	
Baltimore,			21. Signature of Funeral Service Incensee	1	1	Name and Addres 317 Cokes	s of Facility Mo bury Roa	ad, Abin	uneraı gdon,	Home, Maryla	and 21009
			23a. Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death								
7	Physician/ Medical	0 9	Immediate Cause (Final disease or condition								
	Examiner		resulting in death)  Due to (or as a consequence of):								
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	uence of):							
	cuted	xam	Cause (Disease or iinjury that initiated events c.								
_	be exe	Aedical Examiner	resulting in death) Last								
3760	ficate g phys	<b>Jed</b>	<b>a</b> .								
Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/N	IF FEMALE:   23b. Was decedent pregnant in the past 12 mooths?   1						23d. Date of delivery  Month Day		
O. B		hys	g Unknown g Unknown								the course of death?
ls, P.O.									robably 4 🗆 Unknown		
Score		Completed							osy ormed?	prior to c death?	copsy findings available completion of cause of
Œ Œ		10	25. Was case referred to medical 26. Place of Death (Check only one)								
Vit		10 B	examiner? 1 Yes 2 No	spital: 1			er: 4  Nursing I	Home 5 Resid	dence 6 🗆	Other (Speci	ify)
Division of Vital Records,		Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work?  M 28c. Injury at work?  1  Yes 2  No			28d. Describe how injury occurred				
)ivisi			3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - A building, etc. (Special Country) - A building, etc. (Special Country) - A building, etc. (Special Country)						Location (Street and Number or Rural Route Number, City or Town, State)		
_		Medical	29a. Certifier (Check only one)  1								
	To the within To the comp		29b. Signature and title of certifier			29c. License D6691	e number		29d. Date si	gned (Month	
30. Name and address of person who completed cause of death (Item 23a) (Type, Prin							<del></del>	- 361	27 21	000	
	VenKata Parsa 500 Upper Chesapeake Dr., Bel Air, Maryland 21009  State Registrar  31. Date filed (Month, Day, Year) NUV 2 2011  32. Registrar's Signature J.										
	Sta Registi		31. Date filed (Month, Day, Year)	32. negistrar's Signatu	1. A	1600					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Monthem Physician/ :50 Medical Facility Name (if not institution, City, Town, or Location of Death 4c. County of Death **Examiner** Hmore N/A 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. Funeral 74 Director 362-42-6937 1**X** M 2 □ F June 3, 1937 Nebraska Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1 Tes 2 No Maryland Glyndon Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral "natural", or items 23a 2323 Geist Road 21071 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?
1 XYes 2 No 1963
If Yes, Give Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 1965 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) Cardio Vascular Phvsician 2 should be filed w h and Mental Hygid 7 is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Erma Leonard Ross Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health an Important: If item 27 is any injury or other trau 2323 Geist Road Glyndon, Maryland 21071 Carolyn Taylor, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place. 1 Burial 2X Cremation 3 Removal from State 11/22/11 Baltimore, Maryland Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup> Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Signature of Funeral Service Licens Thomas Gregor nat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Other (specify) IF FEMALE: ase 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Dav 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director, After this certificate h 1 ☐ Yes 2 ☐ No 1 Yes 2 □ No Coronal 25. Was case referred t medical examiner?
1 ☐ Yes 2 X No 26. Place of Death (Check only one) Be Hospital: ပ္ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death . Date Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

821 Begistro

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, 37325 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Daniel Turner 07:35 AM 2011 /Medical 4a. Facility Name (If not institution) give street and number) 4b City, Town, or Location of Death 4c. County of Death Examiner Agnes tosp Solfinder

If Under 1 Year If Under 24 Hrs.

Months Dave Harry Date of Birth (Month, Day) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday **Funeral** Hours Days 220.92.225 1 M 2 □ F 45 MD Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show sust be rigified at Baltimore MD 1 Yes 2 □ No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rock 5 Glen USA N, Itams 23a Funera . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. e filed within 72 hours after of Hygiene, other than "natural", or Ital 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry anstruction College (1,4or 5+) Elementary/Secondary (0-12) Laborer Pavers 12th grade 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental ant: If itam 27 is marked o Patricia D. Tumer Morns EWell 19a. Informant's Name/Relationship (Type, Print) (WIFE) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Neisha Shaheed -501 N. Rock Glen Turner Koad Isa Himore MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If its any injury or ot once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 11/29/2011 Greenmount Crematory Bultimore MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Funeral Services iberty Road fundall stown MD 21133 23a. Part1. Entry the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Einal LUNG CANCER **Physician** ICAK disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Vital 1 Yes 2/3 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one, Other: Medical Certification: To 1 Tes 1 K Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death D te f Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Division Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident hours after deat 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours at To tha Funaral D completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Joyce Marie Troup Month 2011 12:45 AM November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Kensington Nursing & Rehab. Center Montgomery Kensington 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** June 4, 1938 Days Hours **Director** 459-60-9604 Texas Usual Residence of Decedent show or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location Director 10d. Inside City Limits MD Montgomery Kensington 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be r Funeral 3000 McComas Ave. 20895 United States within 72 hours after death Was Deceue... Armed Forces? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3XXWidowed 4 □ Divorced Specify. White Completed injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Store Clerk Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Ainsworth Marie Norris Marion Μ. Fannie 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Troup Leighton/ 6100 Princeton Ave., Glen Echo, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Chesapeake Crematory 11/22/2011 Beltsville, MD Name and Address of Facility app Funeral and Cremation Services 33 Gist Ave., Silver Spring, MD any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between ORD NARY Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to himselfate cause. Enter Underlying Examiner Directo for as a nonsecuerine of: attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 5 Other (specify) Pregnant at time of death signed by the at d be detached for 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗚No 3 □ Probably 4 □ Unknown 1 🗆 Yes Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s After this certificate has autopsy performed Yes 2 2 No 1 
Yes the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 KNo Other: မ 1 🗌 Yes Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours af er deat e Funeral Director Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical

State Registrar 29a. Certifier

(Check

only one)

RUONG 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

NOV 22

within 2

Suo, ms

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DO057124

10110 MOLECULAR DR#206 ROCKVILLE MD 20850

29d. Date signed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Grace Mary Tiburzi 2011 Nov. 7:12 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Gilchrist Hospice Center Towson . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Min Director 235-46-3768 1 □ M 2 🔽 F Oct. 12,1931 West Virginia 80 Usual Residence of Deced 28a-f show 10b. County 0a. State 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No Cockeysville MD Baltimore 10e, Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 21030 United States 5 Berrycrest Court Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Maryland 21215-0036 1 Yes 2 XNo Specify Specify: White 3 ▼ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene, is marked other tha 12 Years Cashier Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Frances Raymond Amelio Manzo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co and 2 s Health a James D. Tiburzi (Son) 5 Berrycrest Ct. Baltimore, Maryland 21030 Baltimore, tem 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 1 X Burial 2 Cremation 3 Removal from State Sacred Ht. of Jesus Cem. 11/18/2011 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter in dise shock, or hear failure Immediate Cause (Final or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, diseas Approximate Interval Between Onset and Death Physician/ Medical disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 as the attending IF FEMALE: use yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death the g Unknown 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s has autopsy perform death? this certificate 1 🗌 Yes Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 1 Other (Spe 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Director; Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined after within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier NEP WW)

DHMH 17 Rev 06-2011

State Registrar

31. Date filed (Month, Day, Year)

614

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2011 37328

	1- For State Registrar		Certific	ate of <i>E</i>	Death		Re	g. No.	
Physician/	Decedent's Name (First, Midd)	le,Last)					Date of Death    Month	Day Year	3. Time of Death
Medical Examiner	Cynthia Dawn 4a. Facility Name (if not institutio	Taylor					November	15, 2011	1122 nrs
( ··	4a. Fačility Name (if not institution 7214 Bayfront Road	on, give street and numbe	er)		City, Town, or L Sparrows Po		h	4c. County of Baltimore	
Funeral	5. Social Security Number	6. Sex 7. A	ge (In yrs. last birt	hday)	If Under 1 Year	If Under 24Hr	_		Birthplace (State or
Director	219-66-8824	1 M 2 X F	53	Yrs.	Months Days	Hours Mir	Dec. 14		Foreign Country) Maryland
è	Usual Residence of Decedent  10a. State 10b. County		10c, City, Town	or Location					10d. Inside City Limits
Maryland 28a-f show any d at once. rector		timore	Edgem						1 Yes 2 No
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked inter than "natural", ar items 33a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	10e. Street and Number				Of. Zip Code	-	10	g. Citizen of Wha	at Country?
34 or ptiffer	7412 Bayfront	Road			21219	)		Inited S	tates
b with	11. Mantal Status 1 Never Married 2 M	12. Was Decede			Decedent of Hisp specify Cuban,		pecify Yes or No- o Rican, etc.)	14. Race - White,	American Indian, Black, etc.
er death with , nr items 23. Cmust be no Funeral		1 Yes	2 X No	4 🗀 🗸	o <del>t</del> Z N-			Canait II	T71 * 4 .
ural",	16 B I 15 F 16 16	or Cates:	omnleted\ 16a		es 2X No Usual Occupation		work done	Specify: 16b. Kind of Busi	White iness/Industry
5-0036 ed within 72 hour hygiene. Influer than "natur the Medical Exan	Elementary/Secondary (0-12)	College (1-4 c			of working life. I				,
5-0036 ed within 7. tygiene. nither than the Medical Comple		+2 years	S	ecret	arv-Md.	Transp	Author	itv Tr	ansportation
MD 21215-0036 d 2 should be filed within 7 tith and Mental Hygiene. n 27 is marked rither than numatic event, the Medica To Be Comple	17. Father's Name (First, Middle		1.5	00100	11	8.Mother's Nam	e (First, Middle, M	laiden Surname)	<u> </u>
21.2 be fill rked rked Be	Garth L. Rutter	•				Agnes 1	Pagana		
D 21 hould hould Me is man	19a. Informant's Name/Relations	ship (Type, Print )	117						, State, Zip Code)
ore, MC ss 1 and 2 sl of Health ar If item 27	Keith Taylor  20a. Method of Disposition	(Ex-Spouse)	7 J 20h Blanc	218 R	iver Dri	ive Road	Baltir	nore, Ma	ryland 21219 City or Town, State
ore, stan of Hea Wite	1 X Burial 2 Cremation	n 3 Removal from		ory or other		etery,	Date	200. Eucanori - C	Sity of Town, State
. <u>=</u> ~ 2 3 5	4 Donation 5 Other S		Dulan				. 11/18/	ll Timo	nium, Md.
Baltime permit. Pag Department Important; injury or of	21. Signature of Funeral Service	Licensee		22. Nar Dud	ne and Address of a - Ruck T	of Facility Funera 1	Home of	Dundalk	. Inc.
	23a. Part I. Enter the disease, or	complications that cause	ed the death. Do no	792	2 Wise 4	venue	Dundalk	Maryla	nd 21222 rt Approximate Interval
Physician Medicul	failure. List only one cause	on each line.							Between Onset and Death
xaminer	Immediate Cause (Final disease or condition resulting in death)	a. Hyperten: Due to (or as a cor		erosci	erotic	Cardiov	ascular	Disease	
	Sequentially list conditions,	b							
ner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a nor	sequence of):						
im im	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cor	nsequence of):	_				· · ·	
18 g a Brising	Grants resulting in deathy Educ	d							
760, ficate be executed physician and the burial - transit	X UNPENDED	AMENDED 23	a,27,per	me,g9	22 12-5	-11 sm			
	IF FEMALE: 23b. Was decedent pregnant in the		ome of pregnancy		death 3	Ectopic pregn	ancy	23d. Date of d	delivery Day Year
Sox 687  death certifi e attending for use as t	past 12 months?	4 Pregnant	at time and almostly	_ =	(Specify)		ca 10 y		54,
). Box 68 the death certif by the attending tched for use as	1 Yes 2 No 9 ✔ Un	known 9 Unknown							
P.O. that the med by detache		tions contributing to de	ath but not resultin	g in the und	lerlying cause giv	ven in Part I.			oute to the cause of death?
g, P									Probably 4 V Unknown
Records,  The law requires firate has been sign, page 2 should be Completed		_					24a. Was a autops	sy pr	ere autopsy findings available for to completion of cause of
Cecc The lar ate ha							perform 1 <b>✓</b> Yes 2		eath? ✔ Yes 2 No
ertific ctor, p	25. Was case referred to medica					of Death (Check			
Physician this central director	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpa		utpatient :	201		ing Home 5 .		
1 Of ling P After funera	1 X Natural	28a. Date of I		Time of Inju	'   _ ' '	r at Work?	28d. Describe h	ow injury occurre	d
sior trend death. ctor: y the y	J Fell	stigation				es 2 No	000 1		D 15 11 N -1 - 0'h
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as ledical Certification: To Be Completed by Physician.		Id not be 28e. Place of (Specify)	Injury - At home, fa	arm, street,	factory, office bu	ilding, etc.	or Town, St		r or Rural Route Number, City
Hospi 24 hou Funer rely fil	29a Certifier	hysician: To the best of	my knowledge, de	ath occurre	d at the time, dat	e and place, an	d due to the cause	e(s) and manner a	as stated.
To the Ho within 24 To the Fu completel	one) 2 Medical Exa	miner: On the basis of e		nvestigation	n, in my opinion,	death occurred	at the time, date a	and place, and du	ie to the cause(s)
F FF S	29b. Signature and title of certific				29c. License				d (Month, Day, Year)
•	Munis	roull ME	5		O.C.N	1.E.		November 1	16, 2011
()	30. Name and address of person	•			5 W				
W	Melissa Brassell, MD  31. Date filed (Month, Day, Year)	Assistant Medic	trar's Signature	900 W.	Baltimore St	reet, Baltim	ore, MD 2122	3 	
State Registrar	11011 4 0 -	011 A	A A	and de	5				
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OCME 2006									

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State of Maryland / Department of Health and Mental Hygiene

		For State Registrar		State 0	i iviai yii	Ce	rtificat			and iv	ieritai i iy	Reg. No	ZU		37	329
Physic	ian/	1. Decedent's Name	e (First, Middle, L	ast)							2. Date of De		Day Year		3. Time of	Death
Med				Tomasso							Novem		18 2	011	1:11	P M
Exam	iner	4a. Facility Name (if					, , ,		Location	of Death			. County of			
Funova		2621 Po 5. Social Security No		kout Cov		s. last birthday)		apol r1Year	is If Under	24 Hrs.	8. Date of Bi		nne A		el ace (State o	r Foreian
Funera Directo		475-20-18		1 <b>X</b> M 2 □ F		86 Yrs.	Months	Days	Hours	Min.	(Month, Da	ay, Year)		Count	(y)	roroigir
- MC		Usual Residence o	of Decedent								June J	L4, ]	L925 M	_	esota	
yland -f sho ed at	ctor	10a. State	10b. County			City, Town or L								10	0d. Inside Ci	•
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ural",		3 🛚 Widowed	4 Divorced	If Yes, Giv Year or Da			1 Yes	2 <b>X</b> _  No	Specify	<i>'</i> :			Specify:	Whi	te	
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e, Inda yida in Z IZ IS COOO and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho wher traumatic event, the Medical Examiner must be notified at		19a. Informant's Na	me/Relationship	(Type, Print)		19b. Mai	ling Addres	s (Street a	and Numb	er or Rura	l Route Numb	er, City or	r Town, Stat	te, Zip C	ode)	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury.		20a. Method of Disp		☐ Removal from		b. Place of Disp cemetery, cre	osition (Na ematory or	me of other place	e)		Date	20c. L	ocation - C	ity or To	wn, State	
Page Iment tant: jury o			5 Other (Spe			West Ar					7/2011		dentor	•		
permit permit Depart Impor any in		21. Signature of Fur	neral Service Lice	ensee	N.						naldsoı -				e, P. <i>I</i>	Α.
4 40200		23a. Part 1. Priter t	MUL	3/17	~~~						, Laure		MD 20	0707		
		shock, or hear	rt failure. List onl	y one cause on ea	ich line.	ieath. Do not er	ter the mod	ie or dylrig	g, such as	s cardiac d	r respiratory a	irrest,			Approximat Interval Bet Onset and	ween
Physician Medica	_	disease or condition resulting in death)		a		ary Art	ery D	iseas	se						Oriset and	Douti
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical Examiner			d												
artifica ding p	/Me	IF FEMALE:		23c If yes out	come of pro	onanov.										
ath ce attend for us	cian	in the past 12 i	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1										*	Year		
he de y the	hysi	1 Yes 2 9 Unknown		9 🗌 Unkr						``						
that the red be deta	by P	Part II. Other signif	icant conditions	s contributing to d	leath but not	resulting in the	underlying	cause giv	ven in Parl	t I.	23e. Did	tobacco	use contrib	ute to th	e cause of d	leath?
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VISION or Attending fler death. irector: Afin by the fu	ij	2 Accident 3 Suicide	Investiga 6 Could no	t be	of Injury - A	at home, farm, s	treet, factor		res Z L		28f. Location	(Street ar	nd Number	or Rural	Route Numl	ner
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pspite hours uneral	Medical		XX Certifying P	hysician: To the b	est of my kr	nowledge, death	occurred a	at the time	e, date an	d place, ar	nd due to the	cause(s) a	and manner	as state	ed.	
he Fr	Med	only one) 3	Certifying N	aminer: On the bas lurse Practitioner												anner stated.
		29b. Signature and	title of certifier	1			29	c. License		,		29d. Da	ate signed (			
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 20<sup>Day</sup>2011 Year 8:00pm Muriel Isabel Watters Thatcher Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Examiner Bel Air Lorien of Bel Air i. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Davs Hours March 1 1918 216 32 9854 93 Fallston, Maryland **Director** 1 □ M 2 🗡 F Yrs Usual Residence of Deceder show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location notified at Director Fallston Harford Maryland 1 Tes 2 No 28a-f 109. CIL... USA 10e. Street and Number 10f. Zip Code ö Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 21047 2614 Pleasantville Road permit. Page 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Union Memorial Hospital Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Julia Ella Rockey Walter Archer Watters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1302 Heather Hill Road Baltimore, Maryland 21239 Julia Wernz (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Metro Crematory Inc November 22, 2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimroe, Maryland 21236 21 Synorure of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEMENTIA Physician/ ENDSTAGE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Ordenying Cause (Disease or injury Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic preonancy in the past 12 months?
1 Yes 2 XNo 5 Other (specify) Month Day Year Pregnant at time of death 4 Pregnant
9 Unknown been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by FAILURE TO THRIVE, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? GERD 24a. Was an rerai Director. After this certificate has filled in by the funeral director, page 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\nearrow$  Other (Specify) ၉ 1 Yes 2 No ASSISTED 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director: After injury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 29b. Signature and title of cet 29c. License number 29d. Date signed (Month, Day, Year) 45344 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

SURESH

DHANJANI

UNION AVE HAVRE DEGRACE, MD 21078

State of Maryland / Department of Health and Mental Hygiene 2011 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:15PM 2011 November 16, Medical William D. Thompson 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital <u>Rockville</u> Montgomery Age (In yrs. last birthday) If Under 1 Y Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. (Month, Day, Year) Country) Director 375-20-2591 1 🗶 M 2 🗆 F November 2,1926 Usual Residence of Decedent Michigan 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 1 🗆 Yes 2 🛣 No Potomac Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number er than "natural", or items 23a or the Medical Examiner must be Funeral 20854 United States 8508 Tuckerman Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 

Yes 2 □ No Black, White, etc. þ 1 Never Married 2 X Married 1 X Yes 2 If Yes, Give Year or Dates. 21215-0036 1 ☐ Yes 2 🗓 No Specify: Completed 3 Widowed 4 Divorced WWII White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Automotive Steel Industries 5+ Industry Government Relations permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event, once. Be Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) မ Mary Jane Mason John Chamberlain Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8508 Tuckerman Lane Potomac, Maryland 20854 Janice A. Thompson/ Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park Rockville, Maryland 22. Name and Address of Facility Robert A. Rockville, Inc. 300 west Rockville, Maryland 2085 Pumphrey Funeral Home/ t Montgomery Avenue 50-2805 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumonia Physician/ day Aspiration disease or condition Medical resulting in death) **Examiner** Obstructive Pulmonary Disease reass if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year signed by the at Ves 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Lymphoma cell 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No 24a. Was an performe 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) nours after death.

neral Director: After this confilled in by the funeral dire 1 Yes Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide hin 24 hours a the Funeral C mpletely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Gertifying Nurse Practitioner: To the best of my knowledge, AM 58661 address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Car Dr Rockville, MD 20850 Alexander MD 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Francis Zito Thomas November 2011Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Bel Air Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Min. Hours 220-24-8739 Director 1X M 2 □ F 82 May 27, 1929 Maryland Usual Residence of Decedent 28a-f show 10b. County 10a. State aţ 10c. City, Town or Location 10d. Inside City Limits Director notified MD 1 🗌 Yes 2 😾 No Harford Bel Air ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be items 23a Funeral 205 Red Pump Road 21014 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 1. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc o by 1 Never Married 2 XMarried Maryland 21215-0036 1 Yes 2X No Specify: white "natural", Specify: Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) the M College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Professor College of Notre Dame 27 is marked other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) and Mental ပ Salvatore Zito Concetta Cimino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other tra Carole S. Tucker wife 205 Red Pump Road; Bel Air, MD 21014 Baltimore, 20a. Method of Disposition 1 Buria 2 Crem 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State Department of 1 Buria 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/25/2011 New Cathedral Cem. Baltimore, MD 21. Signature 1050 York Road 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, MD 21204 23a. Part 1. Enter the disease, o omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Part 1/Enter the discuss, shock, or heart failure. Lis Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Drobah disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, It and Cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) and that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) Live Birth
Pregnant
Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month the 9 Unknown o by 23e. Did tobacco use contribute to the cause of death? σ. Left Knee CABG. Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? week pior to death 24a. Was an Hospital or Attending Physician; The law 124 hours after death. certificate has funeral director, page perform 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 □ No Other: မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and tipe of certi 29d. Date signed (Month, Day, Year, 0057223 Name and address of who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapeake (Jun State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Viscidi Month Year E. ose 12:30 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rallimore, Maryland Baltmore Charles now Care Cente 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🔽 F Months Hours May 6. Director 90 Yrs New <u>Jersey</u> 136-18-6937 Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? . Hygiene. other than "natural", or items 23a or ent, the Medical Examiner must be r Funeral 715 Maiden Choice Lane 21228 United States 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3√√ Widowed 4 □ Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) of ith and Mental Hygien 27 is marked other the traumatic event, the Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) t. Page 1 and 2 should be fil tment of Health and Mental rtant: If item 27 is marked ဂ Nicholas Zito Rafaella Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raphael Viscidi / Son 5728 Ridgedale Road, Baltimore, Maryland 21209 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 ី Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 11/22/2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee Allyson K Taylor 22. Name and Address of FacilityCremation Society of Maryland Acultures <u> 299 Frederick Road, Baltimore, Maryland 21228</u> 23a. Part 1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death erebrovasular disease Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to infinediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Unknown 9 Unknowń signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by al fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of Hypertension has page 2 autopsy death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 2 🗌 No 2 No Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Tes 2-1 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) R082382 un M. Butterwork CRUP 11-22-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 709 Maiden Choice Lane, Catonsville, MD 21228 CKNP Butterworth 32. Registrar's Signatur State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEMBER 17 201 8:05 AM Lillian R. Varnauskas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER BALTIMORE TOWSON 8. Date of Birth (Month, Day, ) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Jf Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Months Days Hours Min. Year 19<u>25</u> Mary land 212-20-5890 Nov. Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Catonsville 10f Zin Code 10e Street and Number 10g. Citizen of What Country? ö ms 23a or must be r Funeral 21228 USA 1006 Edmondson Avenue 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. White ٥ ò 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural", Completed 3 XWidowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 Elementary/Seconday (0-12) 12 College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anna (unk) Robert Mellus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward R. Varnauskas Son 224 Edridge Way; Catonsville, MD 21228 20b. Place of Disposition (Name of 20a Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Sykesville, MD 11/21/2011 Lake View Mem. Park Bonation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. ignature of Funeral Service Lice 1630 Edmondson Avenue; Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final -P. seudomonay sepsis Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 1 ☐ Yes 2 € 9 ☐ Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page 1 Yes 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28c. Injury at work? 27. Manney of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending iniury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) · Cynthia Small B 0005134) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N Charles St Baltamore LO 2/201 unthia SOCIANO MD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Amelia Wylie 201 Medical 4a. Facility Name (if not institution, give street and nur or Location of Death 4c. County of Death Examiner Baltimore - Towson Towsor Care If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Hours 1 □ M 2 🔀 F 83 **Director** 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director TOWSON MD Baltimore 1 🗆 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12, Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) Private Donnestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thampson George permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 [5 19a. Inform (Type, Print) Heights Avenue, Apr. C4 Bathmore MD Gaither 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Crestawn Cemeters Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C. Grene Puneral Sovices 21. Signature of Funeral Service Licensee Kandallstonn MD 2133 Koad er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and failure. List only one cause on each line. 23a. Part 1. Enter the shock, or heart for Onset and Death Immediate Cause (Final Dementia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: fyes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year To the Hospital or Attending Physician: The law requires that the death 5 Other (specify) Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Certificate: To Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed death? within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 12 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural iniury 5 Pending Investigation Accident Suicide 1 Tes 2 🗌 No Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Osler Drive 7505 32. Registrar's Signature State Registrar

11-08531 Sheldon Williams Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

heldon William		State of Mary	land / Depar	tment of	Health a					011 3	7330	
		1- For State Registrar	Certi	ificate of	Death ————		10	Reg	. No.	3. Time of D	) ooth	
Physicia Medical Exami		Decedent's Name (First, Middle, Last)     Sheldon A. Willian	ns				- 1		Day Year 13, 2011			
34		4a. Facility Name (if not institution, give street and r 8804 Stonebrook Lane	number)	41	b. City, Town Columbia	i, or Location of	Death		4c. County of Howard	Death		
Funeral		Social Security Number	7. Age (In yrs. las	t birthday)	If Under 1	Year If Under	24Hrs.	8. Date of Birth	(MM/DD/YYYY)	9. Birthplace (State	e or Foreign	
Director		225-66-2315 1 <sub>X</sub> M 2_F	65	Yrs.	Months	Days Hours	Min.	09-04-1	946	Country) Texa	as	
any		Usual Residence of Decedent  10a, State 10b, County	10c. City. T	own or Locatio	on	<del> </del>				10d. Inside	City Limits	
<u> </u>	L	Maryland Howard		Columbia					1			
faryla 28a-f	Director	10e. Street and Number			10f. Zip Coo	le		100	g. Citizen of Wha	tizen of What Country?		
the Nation		8804 Stonebrook Lane			21046				U.S.A.			
th with	Funeral		ecedent Ever in U.S. Forces?			f Hispanic Origi ıban, <b>M</b> exican,			14. Race - White	American Indian, E etc.	Black,	
er dea		3 Widowed 4 Divorced If Yes, Give Y		1 ,	Yes 2 X	No specify:			White			
urs aft tural"	d by	15. Decedent's Education (Specify only highest gr	iness/Industry									
72 ho n "na	eted	Elementary/Secondary (0-12) College										
15-0036 illed within 7' Hygiene. d other than	Comple	4		les								
filed all Hyged oth	Be Co	17. Father's Name (First, Middle, Last) William Charles Williams	aiden Surname) einkz									
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	To B	19a. Informant's Name/Relationship (Type, Print )	n, State, Zip Code)									
e, MD 21215-0036 1 and 2 should be filed within 72 hours a Health and Mental Hygiene. item 27 is marked other than "natura rtraumatic event, the Medical Exami	17	Susan Klein (Friend)	13	_		ok Lane	Co1		ryland 21			
ore, ME es 1 and 2 s of Health an If item 27		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal		ace of Disposit ematory or othe		f cemetery,		Date	20c. Location -	City or Town, State		
imore Pages 1 ment of H tant: If it	١,	4 Donation 5 Other Specify: Atlantic Crematory 11/22/2011 Glen										
Baltimore, permit Pages l at Department of Her Important: If ite injury or other it	Į į	21. Signature of Funeral Service Licensee	al Homes, ia, Maryl	Inc. and 21045	80							
Physician		23a. Part I. Enter the disease, or complications that failure. List only one cause on each line.	caused the death.	Do not enter the	e mode of dy	ing, such as ca	rdiac or	espiratory arres	st, shock, or hea	rt Approxim	ate Interval Onset and	
/Medical Examiner	N I	Immediate Cause (Final disease a. Atheroscl	erotic Cardiova	scular Dise	ease						eath	
			a consequence of):									
	er		a consequence of):	:								
	Examiner	(Disease or injury that initiated	a consequence of):									
executed ian and al - transit		events resulting in death) Last Due to (or as	,									
D, be exection a sician a nurial - 1	edical	UNPENDED AMENDED	)									
Box 68760, edeath certificate be the attending physici ed for use as the burited for use as	cian/Med	23b. Was decedent pregnant in the	s, outcome of pregna birth		al death	3 Ectopic	pregnan	су	23d. Date of Month	delivery Day	Year	
ox 6 eath cerr attendia	sicia	1 Van 2 No 0 Ulabanum	gnant at time of dea	th 5 Oth	er (Specify)						100	
b. Bc the des	Phy	9 008	nown to death but not res	sulting in the ur	nderlvina cau	se given in Par	rt I.	23e. Did tob	pacco use contri	oute to the cause of	death?	
P.O. res that the signed by be detach	by			Ū	, ,	· ·		1 Yes	2 No 3	Probably 4	Unknown	
Records, The law requir ficate has been s	Completed		<u></u> <u>.</u>					24a. Was a		Vere autopsy finding		
eco he law te has	dmc							perform	n <u>ed</u> ? d	eath?	No	
Vital Rec ysician: The his certificate director, page	Φ	25. Was case referred to medical			26.F	Place of Death (	Check or					
Vita hysici this c	To B	examiner?  1 ✓ Yes 2 No Hospital: 1		ER/Outpatient		Other <sub>4</sub>			Residence 6			
Division of Vital tasl or Attending Physician is after death.  al Director: After this certiled in by the funeral directors.			ite of Injury nth, Day,Year)	28b. Time of In	njury 28c.	Injury at Work? Yes 2		28d. Describe h	ow injury occurre	ed		
SiOI Attender death ector: by the	cati	2 Accident Investigation	ace of Injury - At hor	ne form stree	t factory off			ORf Location (St	reet and Number	er or Rural Route No	ımber City	
Divi	Certification:	Suicide Could not be determined (Specif		ne, rami, succ	t, ractory, on	ice building, etc	" <u> </u>	or Town, St		or real reductions	arribor, Orty	
Hospi 24 hou Funer rely fill		29a. Certifier 1 Certifying Physician: To the b	est of my knowledge									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	one) 2 Medical Examiner: On the bas and manne	is of examination an									
нзна	ž	29b. Signature and title of certifier	. ^			cense number			_	ed (Month, Day, Yea	ar)	
		Carde Hel	llau		0	.C.M.E.			November	14, 2011		
41		30. Name and address of person who completed ca Carol Allan, MD Assistant Medica			imore Str	eet Raltimo	re Mr	21223				
	tate			-	miore of	Dailiffic	, iVIL			<del></del>		
Regis		NOV 2 2 2011 Cereu	w B. A	backer								

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···		For Stata Registrar				ficate of i	lealth and Death	ı	Reg. No.		
hysici:		1. Decedent's Name (First, Middle, Li	, ,	ard				2. Date of Dea Month	Day	Year	3. Time of Death
Medic xamin	_	4a. Facility Name (If not institution, gi				b. City, Town, o	Location of Dea		4c. County		
neral		==	Sex 7. Age	314 (In yrs. last b		Cator  If Under 1 Year  Months Days	If Under 24 Hrs		Baltim		lace (State or Foreign try)
ector		5//-36-6585	1□M 2気F 8	3	Yrs.	violitis Days	110dis IIII	Jan. 2	, 1928	Wash	ington D.C
2.		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Loca	tion				1	0d. Inside City Limits
200	į	MD Baltin	ore	-	onsvi						1 ☐ Yes 2 ☒ No
	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Vhat Coun	itry?
	a D	719 Maiden Choic	e Lane HR3	14		21	1228		US	SA	
	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:			as Decedent of H res, specify Cuba Yes 2 No	ispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No no Rican, etc.)	14. Race Blace Specify	e - Americ ck, White, /:	
	Completed	15. Decedent's E (Specify only highest ga		16	a. Decede (Give ki	nt's Usual Occup	ation during most of we	orking	16b. Kind of Bu	usiness/Ind	dustry
ial Hygiene. Id other then "natural", or items 23a or 28e-f show event, the Medical Examiner must be nutified at		Elementary/Secondary (0-12)	College (1-4or 5		life. DO		1)		Own Ho	wn Home	
	Be	17. Father's Name (First, Middle, Las Max Sorg	1)				18. Mother's Na Anna Sc	ame <i>(First, Middl</i> e, hwarz	Maiden Sumam	19)	
	2	19a. Informant's Name/Relationship Katherine Gannor					and Number or F	Rural Route Number			Code)
		20a. Method of Disposition		20b. Place		ion (Name of	m)	Date	20c. Location -	City or To	wn, State
	Н	1 ☐ Burial 2 ☐ Cremation 3 ☐ Other (Spec		1	-	tory or other place e VA Cen	·	1/28/11	Crownsv	7 <b>i</b> 11e	, MD
once.		Signature of Funeral Service Lice		OG)	Fur	Name and Addre	ss of Facility St ne of Ca	erling A tonsvill enue; Ca	shton So e, Inc.	chwab	Witzke
		23a. Partt. Enter the disease, of cor shock, or heart failure. List only	nplications that caused one cause on each lin	the death De	not enter	the mode of dyin	ig, such as cardia	ac or respiratory a	rest,		Approximate Interval Between Onset and Death
i r	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Under vin. Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as continued or	a consequenc	e of):		ndror		,		
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal dea		ctopic pregnancy Other (specify)	,			te of delive	ery Day Year
	ᄩ	Part II. Other significant conditions	contributing to death by	ut not resulting	in the una				shacco use cont	ribute to th	ne cause of death?
	ğ		la tion			erlying cause giv	en in Part I.		/es 2□No	3 🗆 Prob	ably 4 Unknown
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	e Completed by	Afrial Fibri 25. Was case referred to medical			, 11 910 911	erlying cause giv		1 🔲	res 2 No an 24b. yesy med? 2 No	Were auto prior to co death?	psy findings available mpletion of cause of
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	Certification: To Be Completed by	25. Was case referred to medical examiner?  1   Yes   2   No  27. Manper of Death 1   Natural   5   Pending investigate   5   Could not determine  29a. Certifier (check only one)  25. Was case referred to medical examiner?  5   Pending investigate   5   Could not determine	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da) 28e. Place of Inju building, etc hysicien: To the best miner: On the basis of	of my knowled examination :	Outpatient Time of Injury farm, street	3 DOA  28c. Injur Wor M 1 Dot, factory, office  coccurred at the tir stigation, in my office	26. Place of Does: 4 □ Nursing y at k? Yes 2 □ No me, date and place pinion, death occurs e number	24a. Was autop performed at the time,	an sy med? 24b. Vine)  dence 6 Oth now injury occurred and Number Man, State)  cause(s) and madate and place, 29d. Date signe	Were autoprior to cordeath?  I Yes  Per (Specified anner as sand due to d. (Month,	psy findings available mpletion of cause of 2 No 2 No No No No No No No No No No No No No N
completely filled in by the funeral director, page 2 should be detached for use as	Certification: To Be Completed by	25. Was case referred to medical examiner?  1   Yes   2   No  27. Manper of Death 1   Natural   5   Pending investigate   5   Could not determine  29a. Certifier (check only one)  25. Was case referred to medical examiner?  5   Pending investigate   5   Could not determine	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da) 28e. Place of Inju building, etc hysicien: To the best miner: On the basis of and manner sta	of my knowled examination :	Outpatient Time of Injury farm, street	3 DOA  28c. Injur Wor M 1 Dot, factory, office  coccurred at the tir stigation, in my office	26. Place of Does: 4 □ Nursing y at k? Yes 2 □ No me, date and place pinion, death occurs e number	24a. Was autop performed to the control of the cont	an sy med? 24b. Vine)  dence 6 Oth now injury occurred and Number Man, State)  cause(s) and madate and place, 29d. Date signe	Were autoprior to cordeath?  I Yes  Per (Specified anner as sand due to d. (Month,	psy findings available impletion of cause of 2 No No No No No No No No No No No No No

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		•	For State Registrar		· ····a· y ·a··	•	tificate c				Reg. No. 2	011	3733	
	Physicia	n/	1. Decedent's Name (First, Middle	, Last)						2. Date of Dea	ith Day	Year	3. Time of Death	
244	Medic	al			VILLIAMS	5				Novembe	r 19 2	2011	7:35 a <sup>M</sup>	
	Examin	er	4a. Facility Name (if not institution,		iber)		4b. City, Tow					4c. County of Death  N/A		
77	Funeral		JOSEPH RICHIE  5. Social Security Number	HOSPICE 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Ye		der 24 Hrs.	8. Date of Birt	h	9. Birthpla	ace (State or Foreign	
-	Director		219-86-8714	1 🛛 M 2 🗆 F	46	Yrs.	Months Da	ays Hou	rs Min.	(Month, Day SEPT. 3	, Year) 3 1965	Country MARY		
	land show dat	-	Usual Residence of Decedent  10a. State  10b. County			, Town or Lo	cation			DELT.	1703	_	d. Inside City Limits	
	/aryla 8a-f s tified	ect	MARYLAND BAI	TIMORE		ī	BALTIMO	RE					1 ☐ Yes 2 🗓 No	
	the N a or 2 be no	Ē	10e. Street and Number	TITIONE			10f. Zip Cod				10g. Citizen of	What Counti	ry?	
	ns 23. must	Funeral Director	3329 LYNNHAVI					244			U.S.			
	rr deat or iter niner i	by Fu	11. Marital Status 1 □ Never Married 2 □ Man	Armed Fo	dent Ever in U.S rces?	3.   13. \	Nas Decedent f Yes, specify (	of Hispanic Cuban, Mex	: Origin? (Spe ican, Puerto	ecify Yes or No- Rican, etc.)		ce - America ck, White, et		
21215-0036	rs afte rral", ( Exan	ed b	3 - Widowed 4 X Divorced	If Yes, Giv Year or Da	e		1 ☐ Yes 2 🛚	<b>X</b> lo Spe	cify:		Specify	BLACK	!	
5-0	2 hou "natu edical	Completed		t's Education st grade completed)		16a. Deced	dent's Usual Ockind of work do	cupation one during r	most of work	ing	16b. Kind of E	Business/Indu	ustry	
121	ithin 7 ene. • than he Me	Com	Elementary/Secondary (0-12)	College (1	-4 or 5+)		O NOT use reti HANIC	ired)		ŧ	KOONS	FORD		
d 2	iled will Hygir other	Be	12 y r s 17. Father's Name (First, Middle, L	ast)		111101	IANIC	18. M	lother's Nam	e (First, Middle,	Maiden Surnam	ie)		
/lan	d be f Wenta arked atic ev	욘	IRVIN WILLIAM	1S				М	AMIE F	ROBINSON	1			
Maryland	shoul n and l		19a. Informant's Name/Relationsh			-				al Route Number				
e, P	and 2 Health tem 2:		Mamie E. Ford/N	lother	20h P		Lynnha esition (Name o		1	altimore Date	Mary]			
nor	age 1 ent of nt: If it y or o		1XXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State Co	emetery, crer	natory or other	place)	11-28			-	ARYLAND	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service L		OMMUNITY									
<u>m</u>	B a E E		100		_		1206 W	NORTH	AVENU	JE		AL HOM	E F.A.	
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that only one cause on ea	caused the death ch line.	n. Do not ente	er the mode of	dying, such	n as cardiac o	or respiratory arr	est,		Approximate Interval Between Onset and Death	
	Medical		Immediate Cause (Final disease or condition resulting in death)	a	Hom	ROS	ARCUH	rA	m	yxord	2)	3	4 S	
	Examiner			Due to (	or as a consequ	ence oi).							•	
	+	iner	Sequentially list conditions, if any, reading to in module cause. Enter Underlying	b. Due to (	ог ва в повачен	ence of:								
	scuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	or as a consequ	ianca ofi								
	be executed sician and burial-transit	calE	resulting in death) Last	L . Buc to (	or as a consequ	ichice oij.								
Box 6876(	eath certificate b attending physic d for use as the b	/edi		d				<del></del> _						
39 ×	n certi	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, out	come of pregnar Birth 2  Feta	ncy Ideath 3 [	Ectopic preg	nancy				ate of deliver	,	
Bo	e deat the at thed fo	ysici	1  Yes 2 No	4 🗌 Preg 9 🗍 Unkr	nant at time of d nown	leath 5	Other (specif	ý)			IVI	onth [	Day Year	
P.O.	requires that the der been signed by the i should be detached	Completed by Physician/Medi	Part II. Other significant condition	ns contributing to d	eath but not res	ulting in the u	ınderlying caus	se given in F	Part I.	23e. Did to	bacco use con	tribute to the	e cause of death?	
ls, I	uires t in sign uld be	q pa					-			1 🗆 ,	Yes 2 □ No	3 Proba	ably 42 Unknown	
Sor	as bee	plet								24a. Was a			sy findings available of	
Rec	The Is	Com								perfo	rmed?	death? 1 ☐ Yes 2	2 A No	
of Vital Records,	<b>hysician:</b> The law r nis certificate has b il director, page 2 s	Be (	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:				0.1	Death (Check			120	T Homen - T	
of V	ding Phys h. After this funeral di	e: To	27. Manner of Death	28a. Date	of injury	ER/Outpatier 28b. Time of	28c. I	4 ∟ Injury at		ome 5 Resid			HOSPICE	
on (	anding eath. or: Afte he fun	ficat	1 Natural 5 Pendin 2 Accident Investig	gation	th, Day, Year)	injury		work? 1 🗌 Yes 2	2 🗆 No					
Division	or Atte	Serti	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inad 28e. Place	of Injury - At ho ng, etc. <i>(Specify)</i>		eet, factory, off	fice		28f. Location (S City or Tow		er or Rural F	Route Number,	
۵	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical Certificate:	29a, Certifier 1 Certifying	Physician: To the b	est of my knowle	edge, death	occurred at the	time, date	and place a	nd due to the ca	use(s) and man	ner as state	d.	
	n 24 h le Fun le Fun	Medi	(Check 2 L Medical E	xaminer: On the bas Nurse Fractitionar	is of examination	and/or inves	tigation, in my c	ppinion, deat	th occurred at	t the time, date a	nd place, and du	e to the caus	se(s) and manner stated	
	To the within to the comp		29b. Signature and title of certifier	/	/	/	29c. Lic	ense numb	er		29d. Date signe	ed (Month, D	ay, Year)	
			Thirt	h	Jan		10,	325	80		11/1	9/20	)(/	
\ .			30. Name and address of person to the second	who completed caus	e of death (Item	23a) (Type, F	Print)	674 8	3A 7 1	inson	And K	m I for	MAZIONI	
	Stat	е	31. Date filed (Month Day Yay)	011 A2.R	egistrar's Sign	ure .	Ned.	-11.0	1 ) PE	~-/ V WYC IV	rive	eriv!	140(10)	
	Registra	ar	NUVZZZ	UII Skry	m p.	year								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Medical Name (if not institution, give street and number ntv of Death **Examiner** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** 214-44-5039 **Director** 1 🗆 M 2 🛛 F 75 May 24, 1936 South Carolina 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director N/A 1 Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be n Funera 21216 **USA** 2505 W. Lafayette Avenue items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Medical Examiner rmed Forces?

Yes 2 No Black, White, etc. 1 Never Married 2 Married ò ģ Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 1 No Specify: If Yes, Give Year or Dates Specify: Black "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Seamstress Acme Pads 10th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 John Watkins Eloise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6403 Eastern Parkway Baltimore, Maryland 21214 Alease Oliver - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, injury or 1 M Burial 2 Cremation 3 Removal from State Arbutus Mem. Park 11/18/2011 Arbutus, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral Home lle toa 5240 Reisterstown Road Baltimore, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ mona disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine Directo for as a nonsequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trar and Due to (or as a consequence of): nding physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as the IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atter in the past 12 months?
1 ☐ Yes 2 ☐ No for Month 5 Other (specify) Dav Pregnant at time of death ed by the a should be det Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2 🗌 No certificate Yes 1 🗌 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1 Yes 28d. Describe how injury occurred injury 10 Natural 5 Pending 2 🗀 No Accident Investigation 2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature 29d, Date signed (Month, Day, Year) 20 th (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 2

DHMH 17 Rev 06-2011

Registrar

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 37340 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 7:05 Gary Walter Wilhelm November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 1471 Holston Court Hanover 5. Social Security Number 7. Age (In yrs. last birthday) If Unde 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) Country) **Director** 494-44-8088 69 1 3 M 2 D F Yrs August 26, 1942 Missouri Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State must be notified at rector 1 Yes 2X No Maryland Anne Arundel Hanover Ξ 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a Funeral 1471 Holston Court 21076 United States items death 2. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status the Medical Examiner Armed Forces? 1962-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ō 1 Never Married 2 Married þ filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give 1982 "natural", Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Communications Analyst NSA traumatic event, Be permit. Page 1 and 2 should be file.
Department of Health and Mental Humportant: If item 27 is many injury or other. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Walter C. Wilhelm Florence I. Lafser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet B. Wilhelm/Wife 1471 Holston Court, Hanover, Maryland 21076 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November 21, cemetery, crematory or other pla West Arundel Crematory 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Odenton, Maryland 21. Signature of Fun Service Lica 22 Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 M01386 Approximate Interval Between et and Dea 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) signed by the at Id be detached fo 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Probably 4 Unknown Completed peen 24b. Were autopsy findings available 24a. Was an page 2 : prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed certificate Yes 2 N 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 14 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After injury 14-Natural 5 Pending 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month. Dav. Year)

State

Registrar
DHMH 17 Rev 06-2011

31. Date filed (Month, Day,

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1 Decedent's Name (First Middle Last 2. Date of Death Physician/ Month Doris Wildbore Nov 19. 11:20 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 312 Biddle Road Prince George's Accokeek Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, ) 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔽 F Hours Min. South Carolina 69 Director 250 66 8329 1942 Usual Residence of Decedent 10a. State 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If items 23a or 28a-f sho important: If items 23a or 28a-f sho any injury or other traumatic event, Item Medical Examiner must be notified at any injury or other traumatic event, Item Medical Examiner must be notified at 10d. Inside City Limits **Funeral Director** 1 Yes 2 No Maryland Prince George's Accokeek 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20607 312 Biddle Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify: 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Greenhouse/Nursery Master Gardner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Wayne S. Coates Lvda Grace McElrath 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maurice Wildbore (Husband) 312 Biddle Road, Accokeek, MD 20607 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🌠 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place, Maryland Veterans Cemetery Dec 6, 2011 Cheltenham, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) CARCINOMA Examiner 32Yas Sequentially list conditions, Examine if any, feading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events the attending physician and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 ☐ Yes 2 ₹ 9 ☐ Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HEOTHYROIDISM 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 BREAST CANCER performed? Yes 2 N To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No 2 Accident Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 037467 No (NO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alex/Leon, M.D.3261 Old Washignton Road, #3010, Waldorf, MD 20602 32. Registra s Signature State

✓ DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 19, 2011 Beverly Ann Wood 09:15 ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Solomons Calvert Co. Solomons Nursing Center Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours 94 10/28/1917 Maryland Director 214-38-3353 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 No MD Calvert Solomons 10e. Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 20688 13325 Dowell Road United States an "natural", or items Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married i and 2 should be filed within 72 hours after if Health and Mental Hygiene. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Yes. Give Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) 12 yrs. Anne Arundel Co. College (1-4 or 5+) traumatic event, the Secretary Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ၉ Whittle, Jr. Charles A. Lillian S. Murray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $2\overline{0}674$ 19a. Informant's Name/Relationship (Type, Print) 17191 Piney Point Rd Box 187 Piney Point, MD Mrs. Mary Ellen Manning /friend injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 11/22/2011 Odenton, Maryland Nichols Bethel Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic 22. Name and Address of Facility Singleton Funeral & Cremation 100) 2. M01121 Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or conclict tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Atheroscleratic ardio Vasuelas de disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Hypertensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) burial-transit certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant Pregnant at time of death 5 Other (specify) Month Day Year Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Stenosis 1 Yes 2 No 3 Probably 4 Unknown Obstructive Airway divaso 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA • Hospital or Attending Physis 24 hours after death.
• Funeral Director: After this of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🔀 Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation upleted filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie 1 🗲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D-50653 11-19-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4YAN RIKASUZ

Registrar

State

31. Date filed (Mon

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32. Registrar's Si

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 37343 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0545 Jeffrey Wiltbank Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MEDICAL NICIMICO REGIONAL FENINSULD 566156414 6. Sex 8. Date of Birth Month, Day, Year) Aug 14, 1953 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 215-62-1854 Maryland **Director** 58 1 X M 2 - F Usual Residence of Dec 28a-f show 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director MD Wicomico Salisbury 1

Yes 2 □ No 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? must be 23a Funeral 3792 St. Lukes Road 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. o 1 Never Married 2 Married ò 1 X Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 🔀 No Specify: "natural", Specify: White 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. Elementary/Secondary (0-12) College (1-4 or 5+) 12th Sales Clerk Private Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ျှ Edward G. Wiltbank Florence Elliott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eilene Hitch (Sister) 3792 St. Lukes Road, Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 11/18/2011 4 Donation 5 Other (Specify) Ardent Cremation Hanover, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Latimore Funeral Services, PA 2818 E. Baltimore Street, Baltimore MD21224 23a. Part 1. Enter the disease, or comp ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one Immediate Cause (Final melanom a Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause, Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examir that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the that the death certificate IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year 1 ☐ Yes ∠∟ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires the thours after death.
 Funeral Director: After this certificate has been sign. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 2 🗌 No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 - No မြ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Sertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ionat 11/17/11 HO059368 ne and address of person who completed cause of death (Item 23a) (Type, Print) Salishury MO 100 E. Carrell St. 21801 VISULI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Vidya 2011 1:55 P M Wati November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Hebrew Home Montgomery If Under 1 Year If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Months Days Hours Min. 212-25-7236 1 □ M 2 🎛 F 98 Yrs. Dec. 31, 1912 India Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Tes 2 X No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 11303 Potomac Oaks Drive 20850 India 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No 1 ☐ Yes 2 X No Specify: If Yes, Give <sup>Specify:</sup> Asian-Indian 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ghansundar Mangal Basanti Manga1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yogesh C. Garg/Son 11303 Potomac Oaks Drive, Rockville, MD 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State November 20, 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium Bethesda, Maryland 2011 22 Name and Address of Facility Robert A. Pumphrey Funeral Home, 7557 Wisconsin Avenue, Bethesda, 21. Signature of Funeral Service License Bethesda-Chevy Chase, Inc Maryland 20814 illellion M01173 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Failure to Thrive disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical þ Be Completed

**Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760 signed by the at d be detached for icate has been sig r, page 2 should b director, in by the funeral s after death

Certificate: To

Medical

**Funeral** 

**Director** 

show

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ms 23a or must be r ŏ with 1

the Medical Examiner

items ; death v

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permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin

Physician/

Medical

Baltimore, Maryland 21215-0036

notified at

the Maryland

	d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Osteoporos	is	1 Yes 2 🕅 No 3 🗆 Probably 4 🗆 Unknown
		24a. Was an autopsy performed? 1 □ Yes 2 🗓 No 1 □ Yes 2 □ No
25. Was case referred to medical	26. Place of Death (Check	only one)
examiner? 1 ☐ Yes 2 【X No	Hospital:  1  Inpatient 2  ER/Outpatient 3 DOA Other: 4 X Nursing Hor	me 5 Residence 6 Other (Specify)
27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigati	(Month, Day, Year) injury work? on M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	1 28e Place of Injury - At home form street factory office	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D69568

29d. Date signed (Month. Dav. Year)

7.

29c. License number

Registrar

within 24 hours a To the Funeral D

State

ure and title of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check

only one 29b. Signa

> Atchutha Chilakamarri M.D. 6121 Montrose Road, Rockville, MD Registrar's Signal

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 18. Nancy Lee Warthen 10:40 P.M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air Harford 6. Sex . Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Country) Maryland 216 32 4393 1 🗆 M 2 🕱 F Months 12/24/1935 75 Director Usual Residence of Decedent show 10b. County at 10a. State 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director or 28a-f sh notified a Harford Abingdon Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Completed by Funeral 21009 U.S. 3311 Shrewsbury Road If item 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: If Yes, Give White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than ' Elementary/Seconday (0-12) 12th College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked o ڡ Harry Pindell Sylvia Stanley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3311 Shrewsbury Road Abingdon, Maryland 21009 Shelly Neisser / Daughter Health: Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Glen Haven Mem. Park 11/23/2011 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A.
4001 Ritchie Highway Baltimore, Maryland 21225 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the diseas e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. OP Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 5 Other (specify) Month Day Year Pregnant at time of death Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, of Vital 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Certificate: To Be Hospital: Other: 4 🗌 Nursing Home 5 🗍 Residence 6 🗎 Other (Specify) 1 Tes 2. No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending work?
1 Yes 2 No Division Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number DOO 63220 11/19/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

500 MPPER CHESAPEAKEDR, BEL GFORGE BEL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20:03PM NORMAN YOVEMBER 201 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner 4b. City, Town, or Location of Death HOSPITAL HARBOR BALTIMORE N/A al Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗷 M 2 🗆 F Months Hours Month, Day, Year) 15 Country) 218 07 5078 96 Director Delaware Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if frem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Fyaminas must have a second 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 🔀 Yes 2 🗌 No N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2254 Sidney Avenue 21230 U.S. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married X Yes 2 No 1 ☐ Yes 2 XNo Specify: White 3 🗆 Widowed 4 🗆 Divorced Year or Dates. WW II 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Loader Paint Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Harry Norman Wolfe Olivia Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine Lezotte / Niece 35719 Leland Rockwood, Michigan 48173 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State xBurial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 11/18/2011 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part 1. Enter the disease, mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ RESPIRATORY FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner PNUEMONIA Securatively list over the car Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 1 No ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tyes 2 No Investigation 24 hours after deat Funeral Director. 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Division of Vital Records, P.O. Box 68760 within 2

Baltimore, Maryland 21215-0036

State

29b. Signature and title of c

30. Name and address of person

DLUSOLA

Registrar

DHMH 17 Rev 7/2009

ho completed cause of death (Item 23a) (Type, Print) DBAYOMI-DAVIES

29c. License number

RES

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29d. Date signed (Month, Day, Year)

3001 S. HANOVER ST BALTIMORE, MD

NOVEMBER 14 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Lucille Warren Physician/ Month Nov 11. 2011 1950 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Hours 221-92-8387 Director 1 □ M 2 😿 F 54 July 11,1957 Wakefield VA Usual Residence of Decedent 28a-f shov 10b. County within 72 hours after death with the Maryland notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ¹x Yes 2 ☐ No District of Columbia Washington 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ıral", or items 23a o Examiner must be Funeral 1100 Alabama Avenue SE 20020 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify: Specify: "natural" 3 Widowed 4 Divorced Black Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. I **other than** " Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Private Ninth None Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamie S. Warren Catherine Parham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3444 Croffut Place SE, Washington DC 20019 Elizabeth Travers/Friend Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Chesapeake Crematory 4 Donation 5 Other (Specify) 21,2011 Beltsville Maryland 22. Name and Address of Facility Signature of Funeral Service Liousee Robert G Mason Funeral Home Inc Donald R. Gray Good Hope Rd SE Washington DC 20020 23a. Part 1. Enter the disease, or compli shock, or heart failure. List only one s that caused the death e on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death **Physician** disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events I MMUNE DEFICIENCY
SYNDROME The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown signed by the a 9 Unknown P.O. I Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by STAGE Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown SCH120PHRENIT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2X No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 hours after death. uneral Director: After this of ely filled in by the funeral dire 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔼 Natural 2 Accident
3 Suicid 5 Pending 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 [ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1 (

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31 Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician a. M Setella Thersita Whitley Jovember 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HIMOVE ea N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 F 01/03/1970 Maryland 220-64-4787 41 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It e Medical Examination mailing at 1 Yes 2 □ No Director N/A MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2986 Bero Rd. 21227 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. δ Specify: 3 Widowed 4 Divorced Black Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) United States permit. Pages 1 and 2 should be filed within 7:
Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "na any injury or other traumatic event, Ite Medic once. entary/Secondary (0-12) College (1-4or 5+) Postal Service 12th Grade Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Whitley Beverly Pratt ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2126 Westbourne Dr., Credmoore, NC 27522 Trina Rodriguez(sister) altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State on-site Crematory 11/25/11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign 10 Fun ral Service Licensee Joseph H. Brown Jr. Funeral Home PA MD21217 2140 N. Fulton Ave., Baltimore, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Sudders Cardiae Death disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ingestive Sequentially list conditions Examiner Juanti (bras a consequence of): if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed and Due to (or as a consequence of): burial-1 |M|M|HCV, Setellar |M|M|HCVthe attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 □Yes 2 □No Month Dav Year Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 XER/Outpatient 3 □ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after deat e Funeral Director: 6 ☐Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) within 2 and manner stated

Registrar

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Balt more, MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year 08:38 AM **Physician** WINKLER 19 2011 DOLORES NOVEMBER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (Month, Day, Year) 10-22-1932 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Min. 213-28-6614 Maryland 79 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 20-1 any injury or other traumatic event, the Marianing. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No Directo N/A Baltimore City MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21224 USA 425 S. Lehigh Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 💆 No Black, White, etc. 1 ☐ Yes If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: White 2 3 ₩ Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12College (1-4 or 5+) N/A Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward J. Allgeier Julia Marshal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3411 Acton Road Baltimore, MD 21234 Bernard E. Benkowski 20a. Method of Disposition
1 ☐ Burial 2 🖔 Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Bayview Crematory 11-28-2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MO1259 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final **Physician** BRADYCARDIA 10 BJUNIM disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MONTH HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔀 No Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this 27, Manner of Death . Date of Injury (Month, Day Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation or Attending Natural Injury 1 Yes 2 No 2 Accident Director: 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location. (Street and Number or Rural Route Number. 4 Homicide hours after 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar 29b. Signature and title of centific

31. Date filed (Month, Day, Year) NOV 2 2

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29c. License number

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29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

NOVEMBER 19, 2011

and manner stated.

ALADE,

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mabel 09:31AM Hilda Young Derbe Medical 4a. Facility Name (if no institution, give street and numb **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 20 Baltimore **Funeral** Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Days Months Year) Hours 10 04 Country) **Director** 220-22-1462 1 🗆 M 2 🗶 F 84 MD Usual Residence of Decedent show 10a. State 10b. County injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f NA MD Baltimore 1 Yes 2 ☐ No ō 10e Street and Number 10g. Citizen of What Country? Funeral or items 23a 7111 Park Heights Ave Unit 901 21215 as mobel Hilday U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2X No
If Yes, Give
Year or Dates. 1 ☐ Yes 🗝 ☐ No Specify: "natural", Completed 3 ▼ Widowed 4 □ Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene.
7 is marked other than "n Baltimore City Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade 5Yrs+ Educator Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Herbert Hines Sr. Pauline Valentine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Patrethnan-Linda Grant-Daughter 1333 R Street NW, Washington, DC 20009 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) On-Site 11/21/2011 Baltimore, Signature of Funeral Service Licenses March Funeral Home (West) 4300 Wabash Ave, Baltimore, 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart diure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final and Death Staph Aureus Physician/ remonia and Bacteremia disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-tra resulting in death) Last physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) attending IE EEMALE 23b. Was decedent pregnant 23d. Date of delivery ō in the past 12 months? Month signed by the at d be detached for Day 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy vinona performe this certificate Yes 2 1 Yes I or Attending Physician: after death.
Director: After this certific Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital 2 No မ 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann of Death Certificate: Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury Investigation filled in by the Accident М 1 Yes 2 🗌 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours a

To the Funeral E

completely filled Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number

Registrar

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NO

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1/01/2011 Robert P. Adams 5:00am м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Heritage Harbour Health & Rehab. Annapolis Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. 88 <sub>Yrs.</sub> 116-16-8282 **Director** 1 **K** M 2 □ F 10/24/1923 NY Usual Residence of Deced 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes XX No Annapolis MD Anne Arundel 10e. Street and Number 10g. Citizen of What Country? ms 23a or 10f. Zip Code Funeral **USA** 566 Wayward DR. 21401 items death 12. Was Decedent Ever in U.S. Was Decess?
Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Black, White, etc. ö ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes XX No Specify "natural", Completed 3€ Widowed 4 □ Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done duning most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Airline Supervising Mechanic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental | ပ Clara Peck Cedrick Adams t. Page 1 and 2 should be tment of Health and Men tant: If item 27 is marke other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter 566 Wayward Dr. Annapolis, MD 21401 Susan Whaley 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or conce, cemetery, crematory or other place) 1 Burial XX Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 11/3/2011 Glen Burnie, MD 21. Signature of Funeral Service Deensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death <sup>∖ ⊳</sup>h\_sician/ Atherosclerotic Cerebral Vascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Failure to Thrive Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Date to (or as a consequence of). Exami the burial-tran Due to (or as a consequence of): resulting in death) Last nding physician Physician/Medical that the death certificate be Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ jo in the past 12 months? Day Pregnant at time of death Unknown signed by the at Id be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 🕱 No 3 ☐ Probably 4 ☐ Unknown Completed been Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? Director: After this certificate Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 XXNo 1 Inpatient 2 ER/Outpatient 3 DOA XX Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1XXNatural 5 Pending 1 Yes 2 No hours after death. filled in by the Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of c 29d. Date signed Month, Day, Year) 1) 201

State Registrar Colony

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month

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	_	State Registrar				Ce	rtificate of l	Death		Reg. No. 2	01	37352	
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Examin		4a. Facility Name (if not in FutureCare	Chesar		oer)		4b. City, Town, o	r Location of Death			inty of Death e Arur		
Funeral Director		5. Social Security Numbe 215–30–7235	1	ex <b>X</b> M 2 □ F	7. Age (In yrs. 78	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Sept 2	h (5,1933	g. Birtl Cou Mar	hplace (State or Foreign untry) yland	
aryland la-f show ified at	ector		edent . County nne Ari	undel		ty, Town or L						10d. Inside City Limits 1 ☐ Yes 2 🕅 No	
with the M	Funeral Director	10e. Street and Number 525 Bright	view D	rive			10f. Zip Code	108	10g. Citizen USA	g. Citizen of What Country?			
be filed within 72 hours after death with the Maryland ental Hygiene. Ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	þ	11. Marital Status 1  Never Married 2 3  Widowed 4		12. Was Deced Armed Ford 1  Yes If Yes, Give Year or Dat	ces? 2 🗶 No	.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	an, Mexican, Puerto	E	14. Race - American Indian, Black, White, etc. Specify: White			
hin 72 hou ne. <b>than "natt</b> e Medical	Completed	(Specify o		ducation ade completed) College (1-4	1 or 5+)	(Give	edent's Usual Occup kind of work done DO NOT use retired)	during most of work	iing		f Business I		
permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Force.	To Be C	12 17. Father's Name (First,  John Alt	Middle, Last)			ETEC	ctrical In	18. Mother's Nam Erna To			*	ernment	
d 2 should alth and Me 127 is mar ir traumati		19a. Informant's Name/Relationship (Type, Print)  Sophia E. Alt / Wife  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 525 Brightview Drive Millersville, MD											
Page 1 and nent of He ant: If item ant: If or othe		20a. Method of Disposition 1 Burial 2 XCr 4 Donation 5	emation 3	Removal from S	tato.	cemetery, cre	osition (Name of ematory or other place ematory,	Nove	mber 1, 2011	20c. Location	on - City or T		
permit. Departimport any inji		21. Signature of Fane al	An	2		<u> </u>	195 Ritch:	& Sons, P Le Hwy,	.A. Seve	erna Pa	ark Fi	neral Home 1D 21146	
Physician/ Medical Examiner		23a. Part 1. Enter the dis shock, or heart failu Immediate Cause (Final disease or condition resulting in death)	sease, or compure. List only on	a	h line.	ova	ter the mode of dyir			rest,		Approximate Interval Between Onset and Death	
	Examiner	Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events	ate	b. Due to (or as a consequence of):  C. Due to (or as a consequence of):									
ate be exe physician a the burial-i	cal												
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregr in the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	iaiii		irth 2 ☐ Fet ant at time of	al death 3	☐ Ectopic pregnand ☐ Other (specify) _	су			Date of deli Month	very Day Year	
uires that t n signed b ild be deta	þ	Part II. Other significant		4		sulting in the	underlying cause gi	ven in Part I.	23e. Did to			the cause of death?	
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ian: T rtifica ctor, p	Be C	25. Was case referred to examiner?	medical				26. P	ace of Death (Chec	l 1 ∐ Yes k only one)	2 No	1 L Yes	2 ∐ No	
Physic this ce al dire	ျ	1 ☐ Yes 2 No			-		ent 3 DOA Oth	4 Nursing H	ome 5 Resid	lence 6 🗆 (	Other (Speci	fy)	
tending Fasth. tor: After the funera	Certificate:	2 Accident	Pending Investigation Could not be		, Day, Year)	28b. Time o injury	M 1 🗆		28d. Describe h	ow injury occ	urred		
pital or Al burs after or eral Direc		4 🔲 Homicide	determined	28e. Place o building	g, etc. (Specif	(y)	reet, factory, office		City or Tow	n, State)		al Route Number,	
the Hos thin 24 ho the Fune	Medical	(Check 2 L N	ledical Exami ertifying Nurs	ner: On the basis se Practioner: To	of examination of the best of m	on and/or inve ny knowledge,	death occurred at th	on, death occurred a e time, date and pla	t the time, date a ce, and due to the	nd place, and e cause(s) and	due to the c I manner as s	ause(s) and manner stated stated.	
7. 16. 16.		30. Name and address of	rego	, M.D	•		29c. Licenso	7531		DC+06	cr 3	, Day, Year) 1, 2011	
45		30. Name and address of Moh ( + N 31. Date filed (Month, Day	e Si	8601	of death (Iter	n 23a) (Type,	Print) Hwy	miller	sville	M	0 2	1108	
Stat	е	Date filed (Worth Day	17732	011 32. Rg	gistrar's Signa	ature A	house						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:51 Emanuel Theodore Apple Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1**/∑/**M 2 □ F Jan. 25, 1927 **Director** 234-36-6085 84 Pennsylvania Usual Residence of Decedent or 28a-f show e notified at 10a. State 10b. County 10c. City, Town or Location hours after death with the Maryland 10d. Inside City Limits Director 1 🗆 Yes 2 No Maryland Washington Williamsport 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 23a 16756 Edward Doub Road 21795 USA items : Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Marital Status 14. Race - American Indian. Armed Forces? 14 Yes 2 No 1945-Black, White, etc. ō ò 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", Completed 3 Divorced 4 Divorced 1947 Specify. White event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns
any injury or other traumatic event, the Medic (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Garage Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Durward Grafton Apple Mary Catherine Mills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16760 Edward Doub Rd. Williamsport, Maryland 21795 Joyce Hose-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation Donation Nov.11,2011 Williamsport, Maryland Greenlawn Mem. Park 21. Sign re of Funeral Se Deborned Aftenerality Home, P.A. 425 S. Conococheague St.Williamsport, MD 21795 23a. Part r. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final →Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner rivary Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-trans and Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months? Pregnant at time of death Unknown 2 No Yes be detached the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should peen Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsv death? certificate 1 Yes 2 No Yes Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \( \subseteq \text{Yes} ام ا 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 1 Natural 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 □ Yes 2 □ No 24 hours after death. Funeral Director: A: ☐ Accident the f Investigation Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed within 2 To the F 3 [ the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21742 5 Jahmos egistrar's Signatu State Registrar

State Registrar

31. Date filed (Month, Day, Year) NOV 04 2011

Robert P. Fields, M.D., 18109 Prince Philip Drive, #200, Olney, Maryland 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 03, 2011 Physician/ 6:22am Herman Brower Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda Suburban Hospital Social Security Number 9. Birthplace (State or Foreign Country) New York If Under 24 Hrs. If Under 1 Year **Funeral** Age (In vrs. last birthday) 8. Date of Birth 1 X M 2 - F Days Director 070-16-0199 93 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Bethesda 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6105 Montrose Road 20852 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 

Yes 2 □ No If Yes, Give Year or Dates. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WWII 1 ☐ Yes 2 🗶 No Specify: 3 X Widowed 4 Divorced Specify. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Morris Brower Rachel Elkind 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martin Levin - Nephew 9111 Burdette Road, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State King David Mem. Grdns 11/04/2011 Falls Church, Virginia Other (Specify) Fun mal Service 22. Name and Address of Facility Hines-Rinaldi Funeral Home, MOIZ 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) crondry Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated as on the cause (Disease or linjury) Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 F FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No ☐ Yes 2 🗶 No Division of Vital within 24 hours after death.

To the Funeral Director: After this certific To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 X No 4 Nursing Home 5 Residence 6 Other (Specify 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗌 No 1 X Natural 5 Pending injury Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11/3 2011 054336 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Michael Stephen Londner,

NOV 04 2011

31. Date filed (Month, Day, Year)

2 m

0633

November

600 North Wolfe St., Baltimore, Maryland 21230

M.D.,

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Cherry Boxall

4a. Facility Name (if not institution, give street and number) 12:36 PM 11 2011 Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Hedical center Baltimore **Funeral** . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗶 F Days Hours 10/13/1957 Director 577-96-1448 Indonesia 54 Usual Residence of Decedent ems 23a or 28a-f show must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Montgomery Gaithersburg 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19427 Brassie Place 20886 USA 11. Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? "natural", or i 1 X Never Married 2 ☐ Married filed within 72 hours after þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify 3 Widowed 4 Divorced Specify: Indonesian Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the vrs Secretary Lawn & Power Equip. Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk and Mental F is marked o ပ and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a 19427 Brassie Place, Gaithersburg, MD 20886 Edward Eugene Wade/friend Baltimore, Important: If item any injury or other 20a. Method of Disposition 20b. Place of D cemeter) Disposition (Name of crematory or other place) Page 1 a Date 20c. Location - City or Town, State ₹ Cremation 3 Removal from Stans 5 Other (Specify) Ardent Cremation Sv 11/04/2011 Hanover, MD Funeral Service Lic Signatur 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disea se, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) liver Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Exert Underlying Cause (Disease or imjury that initiated separately in the cause of the cause o Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ☐ Live Birth 2 ☐ Focus 300 ☐ Pregnant at time of death ☐ Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year ed by the a 9 Junknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No this certificate 2 No 1 Tyes Division of Vital 25. Was case referred to medical Hospital or Atter ding Physician: ipleted filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 2 X No Other: 1 Yes မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending Investigation 1 Yes 2 No Accident Cirector: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, after determined To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 1659670214 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Greene Justin Britton St. Bultimore

DHMH 17 Rev 7/2009

State

Registrar

Day, Year)

NOV 04 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 37357 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Elizabeth A. Bartha 1635 M October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Manor Care Chevy Chase Montgomery Chevy Chase Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
New Jersey 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** April 29 157-22-7290 **Director** 80 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Chevy Chase 1 🛛 Yes 2 🗌 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8700 Jones Mill Road. RM-78 20815 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Yes 2 X No
If Yes, Give
Year or Dates. 2 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed Caucasian event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) NIH Medical Tech permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked othany injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Talitha Rose Alex Bartha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8101 Connecticut Ave., #S-600, Chevy Chase, MD 20815 Constance Forster/Personal Rep. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/08/2011 Brentwood, Maryland Lincoln Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD20904 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line set and Death Minutes Immediate Cause (Final Physician disease or condition resulting in death) Myocardial Infarction Medical Due to (or as a consequence of Examiner <u>Coronary Artery Disease</u> Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury Hypertension Years that initiated events resulting in death) Last Due to (or as a consequence of): ending physician use as the buria Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 month 1 Yes 2 X No Day the P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Osteoporosis 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Anemia 24a. Was an cate has page 2 s autonsv 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 A Residence 6 Other (Specify) 1 🗌 Yes 2 🗶 No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this gampleted filled in by the funeral di Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Marse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certif

Raman

Tuli

**NOV 04** 

M.D.

on who completed cause of death (Item 23a) (Type, Print)

10810 Darnestown Road.

29d. Date signed (Month, Day, Year) November 01, 2011

#202, Gaithersburg, Maryland 20878

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARY L. BOOTH NOVEMBER 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER BEL AIR HARFORD 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Months Days MARCH 29, 229-26-4865 97 Yre 1914 NORTH CAROLINA **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND HARFORD JOPPA 1 Yes 2 X No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of Funeral 304 OAKWAY COURT 21085 UNITED STATES 12. Was Decedent Ever in U.S. Was Deceue... Armed Forces? Ves 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married by  $l(l|\mathcal{O}|2\mathcal{O}|l)$  Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: 3 X Widowed 4 □ Divorced Specify: BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygier 7 is marked other t NURSES AIDE HOSPITAL traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည ISSAC BARNES MOLLY (UNKNOWN) BARNES permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LYNETTE BARMER / GRAND DAUGHTER 304 OAKWAY COURT, JOPPA, MARYLAND 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🗆 Burial 2 🗆 Cremation 3 🗶 Removal from State HAMPTON MEMORIAL GRDS 4 ☐ Donation 5 ☐ Other (Specify) 11/14/11 HAMPTON, VIRGINIA 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee -60 552 LEWIS STREET, HAVRE DE GRACE, MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ENCEPHALOPATHY ANOXIC Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** HYPOGLYCEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exam Due to (or as a consequence of): resulting in death) Last Physician/Medical 411812008 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death Dav Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MELLITUS 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed HYPOTHYRODISM 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform Yes 2 W No 2 🔲 No 1 Tyes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 Yes 2 **7** No Other: မ 1 Na Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours Medical Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier :ompleted (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) how Now DOPO95 NOVEMBER 7, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FOLFORD MENUE, BEZAIR, MO 2/0/4 ANDREW NOWAKONSKY MD. 35 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

parke

32. Registrar's Signature

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Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiewith Important: If them 27 is marked other than "matural?, or items 23a nr 28a-f abo injury ar other traumatic event, the Medical Examiner must be notified at once.	B	17. Father's Name  Joseph B	owie		1			Hele	n Ta	-			
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Physician // // // // // // // // // // // // //		23a. Pan I. Enter the failure. List on	ne olsease, or comb ly one cause on ea	ications that caused to ch line.	he death.	Do not enter th	ne mode of dying	g, such as ca	ardiac or r	espiratory an	rest, shoc	k, or heart	Approximate Interval Between Onset and
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Division ital or Attendin us after death.	Certification	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Inju			t, factory, office	building, etc.		or Town, S 44 Suitland	state)		al Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical C	29a. Certifier (Check only 1	Certifying Physicia Medical Examiner:	n: To the best of my On the basis of exam	knowledge	e, death occurr	red at the time, o	late and place	ce, and du	ue to the caus	se(s) and	manner as state	ed. e cause(s)
To with	Me	29b. Signature and	title of certifier	and manner stated.			29c. Licen	se number			29d. Da	ate signed (Mor	th, Day, Year)
		Cara	e He	llav			O.C	M.E.			Nove	mber 2, 201	1
23		Carol Allan,	MD Assistar	ompleted cause of de nt Medical Exam	iner 9	00 W. Balti	imore Street	, Baltimoi	re, MD	21223			
St Regist	ate trar	31. Date filed (Mont	82011	32. Registrar	Signat	well							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Earl Boyce William November 08 1:40P M 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Lions Center for Rehab & Ext Care Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 94 Director 288-01-0877 08/27/1917 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director MD Allegany 1 ☐ Yes 2 ☑ No Corriganville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 11111 Pauline Avenue, NW 21524 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Narried 1 ☐ Yes 2 ☑ No Specify: 2 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7's Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ns any Injury or other traumatic event, I'm Medis once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Tire and Rubber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Ollie Boyce Zoe Stockwell 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda E. Bovce / Wife 11111 Pauline Avenue, NW, Corriganville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) White Oak Cemetery 11/13/2011 Meyersdale, PA 21. Sit nature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events Examiner Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Year 5 Other (specify) 1 Yes - A Vit 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

Box 68760, P.O. |

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The law requires that the death certificate be executed signed by t Division of Vital Records, certificate has or Attending Physician: After this r death. Director: within 24 hours after or To the Funeral Direct completely filled in by To the Hospital

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Registrar

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(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NOV

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shakil

625 32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

00046346

Ave, Cumberland

29d. Date signed (Month, Day, Year)

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 X Married 3 Widowed 4 Divorced	Armed Forces?		If	Yes, spe	ecify Cubar	n, Mexican,	Puerto	Rican, etc.)		Black, White		
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should and Ma is mar aumati		19a. Informant's Name/Relationship			19b. Mailin	g Addres	ss (Street a	nd Number	or Rura	l Route Numbe				
and 2 Health tem 27 other tr		Pauline Bennett 20a. Method of Disposition	: - Wife	20b. Pla	11605 ace of Dispos			e Dr.		lver Spoate		Maryl on - City or	Cand 20902 Town, State	
Page 1 annument of Fants: If its		1 🔀 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 Ā Other (Spe	☐ Removal from State	ce	metery, crem	atory or	other place						Maryland	
permit. Departi Import any inji		21. Signature of Funeral Service Lice		012	101 22.	Name a	nd Addres	s of Facility	Hin	res-Rina	uldi F	uneral	Home, Inc. Ing. MD20904	
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Attendi death. ctor: A	Certificate:	2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Injury	- At hon	ne, farm, stre	M et, facto		Yes 2 1		28f. Location (S	Street and Nu	mber or Rur	al Route Number,	
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To the confine		29b. Signature and title of certifier	C MAS			29	c. License				29d. Date si			
10+1		30. Name and address of person who	//					041624					8, 2011	
		G. Patrick Murk	hy, M.D., 1	500	Foresi	t Gle	en Ro	ad, S	ilve	r Spri	ng, Ma	rylano	d 20910	
Stat Registra	e ir	31. Date filed (Month, Day, Year) NOV 0 7 201	2. Registrar's	A.	par	het.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Robert G. Beaumont Sr. Physician/ October 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 9720 Owen Brown Road Columbia Howard . Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Days Min 04/01/1932 1 XM 2 1 **Director** 074-26-3043 79 Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City. Town or Location Director MD Howard Columbia 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be items 23a Funeral 9720 Owen Brown Road 21045 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, , or 1 X Yes 2 Nol 950à 1 Never Married 2 X Married Baltimore, Maryland 21235-0036 1 Yes 2 No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced 1952 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) other than Automotive Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Car Dealer Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked ပ George Hyman Gean Dooley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Loretta Beaumont / Wife 9720 Owen Brown Road Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 5 cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State injury o 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 11/02/2011 Falls Church, VA 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Ligensee 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Chronic Obstructive Pulmonary Disease disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examin requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ 23d. Date of delivery in the past 12 months? Pregnant at time of death 1 Yes 2 9 Unknown 2 No 9 Unknown P.O. nas been signed be 2 should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 X Nc page 1 Yes Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 **X**No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending X Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completed filled in by the fun 2 No Accident 1 Yes Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

37363

5:30

9. Birthplace (State or Foreign Country) New Jersey

10d. Inside City Limits

Approximate Interval Between

Onset and Death

Day

2 No

1 X Yes 2 No

A M

State Registrar

10

aucell

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Maureen Kelley CRNP VA HBPC 3900 Lock Raven Blvd. Baltimore, MD 21215

KO 51063

Registrar DHMH 17 Rev 06-2011

State

Box 68760

P.O.

Records,

Division of Vital

3305 N. Leisure World Blvd., Silver Spring, MD 20906

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Charlene Ozanne-Blankard, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mildred Patricia 2011 Brewbaker Medical November 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Emeritus Senior Living Hagerstown Washington Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign If Under **Funeral** 1 - M 2 - T Months Davs Hours 05/06/1920 Mary Land 213-18-8840 **Director** 91 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City. Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Washington Hagerstown 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? Funeral 20009 Rosebank Way 21742 USA or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No "natural", Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filled within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 th Clerk Retail Department Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Paul Charles Grove Hazel Irene Wolverton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia I. Weaver / Daughter 10590 Longwood Drive, Waynesboro, PA 17268 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important; If ite any injury or ot 1 😾 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Greenlawn Memorial Park 11/10/2011 Williamsport, MD 22. Name and Address of Facility Gerald N. Minnich Funeral Home Signature of Funeral Service Licenses 305 N. Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ eom disease or condition resulting in death) elmei Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): physician and s the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Box 68760 as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ģ 5 Other (specify) Pregnant at time of death the Unknown 9 Unknown P.O. I signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate 2 No 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No Hospital: Other: 1 Tyes Assited Lin ᅆ ER/Outpatient 3 DOA 1 Inpatient 2 I 4 Nursing Home 5 Residence After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural he Funeral Director: Aff 5 Pending work? 1 ☐ Yes 2 ☐ No. Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f, Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical 29a. Certifier 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier

State

Registrar

368 nuel

30. Name and address of person who completed dause of death (Item 23a) (Type, Print)

C

NAFI

028365

street Hagestonn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 10:50.4M 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Mandrin House Harwood Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🔽 Months Days Hours Min Sept. 10,1929 379-24-0289 82 Director Michigan Usual Residence of Decedent 28a-f shor 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1X Yes 2 □ No MD Anne Arundel Annapolis 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? by Funeral 23a 1200 Chrisland Court 21403 United States within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, the Medical Examiner 6 1 Never Married 2 Married 1 Yes XX No If Yes, Give Year or Dates. 3altimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: "natural", 3√√ Widowed 4 □ Divorced Specify: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Operating Communications event, 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F မ Charles Petty Frances Cooley other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 is any injury or att 1200 Chrisland Court Annapolis, MD 21403 Darrel Kent/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dorpation 5 ☐ Other (Specify) Robinson Cemetery Nov.4,2011 Bloomingdale, MI 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Serv Licensee Ridgely Avenue Annapolis, MD 21401 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ck, or heart allue. List only one cause on each line. Approximate Interval Between Imm Mate Cause (fina disease or condition re witing in death) Physician/ **Medical** Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury Exami physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 nding p IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ atten in the past 12 months?

1 Yes 2 No for Day Yea Pregnant at time of death the detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 nknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed' certificate 2 🗌 No Yes 2 Libro 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: မ 1 Yes 2 11100 1 Inpatient 2 ER/Outpatient 3 IDOA the Funeral Director: After this in the funeral dilection of the funera 4 Nursing Home 5 Residence 6 Whither (Sp 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier T death (Item (Type Print) HUNAPOLIS, M.D. 21401

DHMH 17 Rev 7/2009

State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day ynthia (u2manes 30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Howard County General Hospital Columbia 8. Date of Birth (Month, Day Ye Dec 20, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 1 M 2 XX Months Days Min <sup>Year]</sup> 19<u>46</u> 64 Director 152-34-4813 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location Director MD Howard Ellicott City 10e, Street and Number 10g. Citizen of What Country? Funeral U.S.A. 12016 Grayton Drive 21042 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Completed by Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. "natural", 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) other than College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Teacher Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) marked 2 Dan Keromitis Anna Fidek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul T. Cuzmanes - Husband 12016 Grayton Drive, Ellicott City, MD 21042 20a. Method of Disposition o. Place of Disposition (Name of Greek of math not (name) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 5 11-5-2011 Woodlawn, Maryland injury o 4 Donation 5 Other (Specify) Cemetery 21. Signature of Funeral Service Licens 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, MD 20715 23a. Part 1. Enter the disease, or complication what caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Precumonia Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) -transit and Due to (or as a consequence of): resulting in death) Last physician a sthe burial-1 Physician/Medical certificate be 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🗹 No Other: 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death e Hospital or Attending Pl 124 hours after death. e Funeral Director: After the letted filled in by the funeral Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Tes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DOOGG SIS Oct 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5755 Cedar Lane, Columbia, MD 21044 Nishi Rawat, M.D., Date filed (Mont) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1750

9. Birthplace (State or Foreign

10d. Inside City Limits

Annroximate Interval Between Onset and Death

1 Yes 2XXNo

New Jersey

2011

Howard

 Race - American Indian. Black, White, etc.

Specify: White

23d. Date of delivery

1 🗌 Yes

30

2011

Day

24b. Were autopsy findings available prior to completion of cause of death?

2 1 No

Year

Month

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		Registrar  1. Decedent's Name (First, Middle, La	est)		00	i iiiicale Ui	Deall		2. Date of De	Reg. No.	201	╀	3. Time of Do	<u> </u>
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ji			d Medical Ce				nore							
Funeral Director			Sex 7. Age I □ M 2 🕱 F	(In yrs. la	ast birthday) Yrs.	If Under 1 Yes Months Day		ler 24 Hrs. Min.	8. Date of Bir (Month, Da	ay, Year)			ce (State or F ton,	
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vith th	Funeral Director	6123 Lamont Drive				10f. Zip Code 2078				10g. Citiz	ren of What C	Ountry	7?	
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filed tal Hy d oth event	To Be	17. Father's Name (First, Middle, Last)							e (First, Middle,		umame)			
uld be I Men narke natic	-	Jay Hunter Haun							ve Pers					
2 sho th and 27 is r traun		19a. Informant's Name/Relationship (				ng Address (Stre Kent Fo							te)	
I and F Heal Item 2		Jim Cocchiaro – 20a. Method of Disposition	Son	20b. P	lace of Dispe	sition (Name of			Data		cation - City o		. State	
age nent o nt: If ry or		XX Burial 2 Cremation 3 C 4 Donation 5 Other (Spec.		For	emetery, created to Linc	natory or other p	lace) etary	11/3	/2011		twood			d
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licen	**			2. Name and Add		<u> </u>		Evans	Fune	ra 1	Home	
99 <b>=</b> 8 8		Cilla Shute	>			6000 An								
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Physician/ Medical		Immediate Cause (Finat disease or condition resulting in death)	a acute	· W	relaid	1 leuk	emia					0	nset and Dea	ath
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nysici iis cer direc	일	examiner? 1 Yes 2 No	Hospital:	nt 2 🗆	ER/Outpatie		ther:		me 5 Resi	dence 6	Other (Spe	cify)	-	
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after after Direction by		4 Homicide determined	28e. Place of Injurbuilding, etc.			eet, factory, offic	9		28f. Location (3 City or Tov		Number or R	ural Ro	ute Number,	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Medical	29a. Certifier 1 Certifying Phy	sician: To the best of r	ny knowle	edge, death	occured at the tir	ne, date an	id place, an	d due to the ca	ause(s) and	manner as s	tated.		
the Ho nin 24 the Fu	Med	only one) 3 L. Certifying Nur	iner: On the basis of ex se Practioner: To the b	amination sest of my	and/or inves knowledge,	tigation, in my opi death occurred at	nion, death the time, da	occurred at ate and plac	the time, date a e, and due to th	and place, a ne cause(s)	and due to the and manner a	cause s state	(s) and manne	er stated.
No.		29b. Signature and title of certifier	NA				nse number			. 1	signed (Mon	th, Day	(, Year)	
14		patr /h	MD	-Ab /**	00-1/7		728	109		1013	31/11			
45		30. Name and address of person who Kate Gibson, 22 Sou	th Greens St			MD 3	112 ~							
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Registra	r	NUV U 3 2	UII Sener	w	1. 1	back								

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** VOVEMBER 1 2011 EVELYN LOUISE CLARK /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **FUTURECARE** ARNOLD ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral Months Days Hours Min. 1 ☐ M 2 💢 F 95 12/22/1915 PENNSYLVANIA Director 165-38-3003 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dira Examiner must be notified at 1 ☐ Yes 2 XNo Director ARNOLD MARYLAND | ANNE ARUNDEL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 736 MATCH POINT DRIVE 21012 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 ☑ No Specify: ģ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 HOMEMAKER OWN HOME permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygic Important: If item 27 Is marked other i any Injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SIDNEY ALAN FITZGERALD EDNA JULIA MCCLELLAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DENNIS CLARK/SON 842 MILL CREEK RD, ARNOLD, MD 21012 20h. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) CHESAPEAKE CREMATION CENTER 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/05/2011 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility T BY FELLOWS, FINE 2140 PARE, manien 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEMENTIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 1 Tyes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No P

**Physician** /Medical Examiner

within 72 hours after death

Hygiene.

Baltimore, Maryland 21215-0036

burial-trar attending physician the

death certificate be executed

P.O. Box 68760,

been signed by the should be detached certificate has After this funeral

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only

Division or Vital Records, To the Hospital or Attending I within 24 hours after death.
To the Funeral Director; After

State Registrar

Certification:

Medical

Other: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29b. Signature and title of certifier

, m.D. D57531

29d. Date signed (Month, Day, Year) NOVEMBER 2, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8601 Velerans May Millersville, nd monit Negi 32. Registrar's Signature park 31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day, 2011 Ju Chen Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death chever Prince 15 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F 8-3-1919 Hours China Director 92 212-43-9120 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 28a-f 1 X Yes 2 ☐ No MD Prince George's Lanham 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral 9311 Copernicus Drive 20706 China 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 5 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Midowed 4 Divorced Specify. Completed Asian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Private traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 9311 Copernicus Drive Lanham, MD 20706 Tian Cun Zhang/ Son other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Fort Lincoln Cemetery 11-8-2011 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD permit. 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Fineral Service Licens 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Hematoma Physician/ Subdural disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** DOXIC Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the effection of the proper use as the burial-transit Treumor that initiated events resulting in death) Last closed head Tracem Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Yes 24a. Was an 24b. Were autopsy findings available autopsy performed prior to completion of cause of death? 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examino? Hospital Other: 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Fell Certificate: ☐ Natural 5 Pending Lone Accident Investigation Marsham 1 Yes 2 No October 17 2011 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 9311 Copyrights determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Da

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2011 Nov. 1, 10:00 pm Carlos Castro Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 8 Date of Birth **Funeral** 9. Birthplace (State or Foreign Hours 0777071939 Dominican **Director** 1 XM 2 🗆 F 577-04-3441 72 Republic Usual Residence of Decedent or 28a-f show notified at 10a State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Md. Montgomery Silver Spring 1X Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a or Funeral 11525 February Circle #301 20904 U. S. A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, et Specify: þ ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No 1 X Yes 2 No Specify: Dominican If Yes, Give Year or Dates 3 Widowed 4 □ Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) State Government the Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ith and Mental F 27 is marked of traumatic ever i. Page 1 and 2 should be fili tment of Health and Mental tant: If item 27 is marked of jury or other traumatic eve Carlos Blondet Emilia Castro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Silver Spring, Mo Nestor Castro (Son) 11525 February Circle #301 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven 11/07/2011 Silver Spring, Md 22 Name and Address of Facility
W. H. Bacon Funeral Home,
3447 14th Street, NW Wash Signature of Funeral Service Ka Inc. Mucia Washington, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Respiratory Failure Medical Due to (or as a consequence of) Examiner Bilateral Pneumonia Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Due to for es e nonsequence of) **To the Hospital or Attending Physician**: The law requires that the death certificate be **e**xecuted the burial-trans Systemic Inflammatory Response Syndrome signed by the attending physician and that initiated events resulting in death) Last Physician/Medical Metabolic Encephalopathy Division of Vital Records, P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death Month Year 1 ☐ Yes ∠ L g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed' 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 XNo Other: Certificate: To 1 Tes 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending work within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. of pyknowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the be 29b. Signature and title 30. Name and address of pe no completed cause of death (Item 23a) (Type, Print)

State

Registrar

Alphonsus Okoli,

31. Date filed (Month, Day, Year

NOV 07

M.D.

Registrar's Signar

1500 Forest Glen Rd. Silver Spring, Md. 20910

11-08525 Thomas Chrisler

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37372 2011

		- For State		Certific	ate of	Death		_	Reg.	No.		
Physicia		Decedent's Name (First, Middle, Last	)			2. Date of Death  Month Day Year  03.15 bro						
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		Prince Georges Hospital C					1011-1	ōu lo E	No. of Dieth (			nto or
Funeral		5. Social Security Number 6. Se		e (In yrs. last bir	thday)	If Under 1 Year Months Days	If Under Hours	A Con			Birthplace (Sta Foreign	
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<b>=</b> a = a = 1	ŀ	20a. Method of Disposition		20b. Place	of Disposit	ion (Name of ceme	etery,	Date	e 2	20c. Location -	City or Town, Stat	te
MOFE, Pages 1 an nent of He ant: If ite	- 1	1 X Burial 2 Cremation 3			tory or oth	erplace) Laven Cen		11/16	12011	Ciluan	Cntina	un
Baltimor permit. Pages Department of Important: If	-	4 Donation 5 Other Specify.  21. Signature of Funeral Service Licer		Gale	22 N	ame and Address of	of Facility	11/10/ Uinas	Dingl	di Euro	spicity,	TNO
Baltil permit. Departm Importa	- 1	21. Signature de diferan service Licer	1300			00 New H						
Dhysisian	$\dashv$	23a, Part   Enter the disease, or comp	olications that caused	the death. Do n	ot enter th	e mode of dying, s	uch as ca	rdiac or resp	iratory arrest	, shock, or hea	art Approxi	mate Interval
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387 rtifica ling p		23b. Was decedent pregnant in the past 12 months?	1 Live birth	· · · · · · · · · · · · · · · · · · ·	- =		Ectopic	pregnancy		Month	Day	Year
Box 687 re death certific the attending p	Physician/	1 Yes 2 No 9 Unknow		t time of death	5 Oth	er (Specify)						
<b>⊞</b> ° ₹ 8	چ	Part II. Other significant conditions		h but not resulti	na in the u	nderlying cause giv	ven in Par	t I.	23e. Did toba	acco use contri	bute to the cause	of death?
Il Records, P.O. in: The law requires that the riffcate has been signed by itor, page 2 should be detach.	Š	Part II. Other alginiteant containent	contributing to doct	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		,			1 Yes	2 No 3	Probably 4	Unknown
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Division of Vital Records, ral or Attending Physician: The law requirers after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should the	iji Liji	3 Suicide 6 Could not	be	njury - At home,	farm, stree	t, factory, office bu	uilding, etc		or Town, Sta		er or Rural Route	Number, City
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	2	29b. Signature and title of certifier	V			O.C.N			- 1	November		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 37373 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201<sup>Year</sup> October 29 10:19 M Allen L. Dustin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral Days Months Hours (Month, Day, Year) 76 Director 577-44-5041 1**XX**M 2 □ F Vrs Aug. 9, 1935 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits ms 23a or 28a-f shor must be notified at 10a. State 10c. City. Town or Location Funeral Director Bowie Prince George's XX Yes 2 No MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20715 12507 Shetland Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in U.S. 14 Race - American Indian Examiner Armed Forces?

1XXYes 2 No Army Black White, etc. 5 þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after 3 Baltimore, Maryland 21215-0036 1 Yes 2 XXo Specify If Yes, Give Year or Dates Specify: "natural", White Completed 3 ₩Vidowed 4 □ Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Stationary Engineer Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Earl Samuel Dustin Sarah Elizabeth Musgrove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once, 3511 Mase Lane, Bowie, MD 20715 Allen L. Dustin II - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 11-2-2011 Brentwood, MD Lincoln Cemetery Donation 5 Other (Specify) Beall Funeral Home 6512 NW Crain Hwy, Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ neumonia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) detached the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by artery 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy has page 2 Diubetus this certificate 1 Yes 2 No Yes 2X No or Attending Physician: 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2'No 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certi-29c. License number 29d. Date signed (Month, Day, Year) ē 1) 2804 10-26-2011

Registrar

DHMH 17 Rev 06-2011

State

21401

Name and address of person who completed cause of death (Item 23a) (Type, Print)

nno

. Degistrar's Signat

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Funeral Director		5. Social Security No. 106–16–47.		. Sex 1 <b>X</b> M 2 □ F	7. Age		st birthday)	If Under 1 Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D		)		hplace (St intry)	tate or Foreign
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To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the funeral Director.	Medical	29a. Certifier 1 (Check 2	Certifying P	hysician: To the b miner: On the bas	est of m	ny knowle	dge, death o	occurred at the	he time,	, date and	place, an	d due to the o	ause(s)	and man	ner as sta	ited.	d manner state
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Emma Davis October 2011 12:30 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ft. Washington Rehab. & Health Ctr. Ft. Washington Prince George's Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year Funeral 8 Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🛛 F Davs 101-18-5360 95 1671471916 North Carolina **Director** Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Ft. Washington 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8705 Grasmere Court USA 20744 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2XX No Black Specify 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 7th College (1-4 or 5+) Childcare Childcare Provider Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Holmes Gus Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8705 Grasmere Court, Ft. Washington, MD 20744 Linda Houston / Niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State Resurrection Cem. 11/04/2011 4 ☐ Donaţion 5 ☐ Other (Specify) Clinton, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signatu 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one caus, on each line. Immediate Cause (Final disease or condition Physician/ Medical resulting in death) <sup>H</sup>Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence on). Exami Cause (Disease or linjury and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Petal death Pregnant at time of death Ectopic pregnancy in the past 12 month 5 Other (specify) Month 1 ☐ Yes 2 ∆ 9 ☐ Unknown sate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate Yes 2 X No 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 KNursing Home 5 Residence 6 Other (Specify, 2XXNo Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 5 Pending work? 1 ☐ Yes 2 ☐ No 1XX Natural injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 XXCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) LINE CENTER WALKE istrar's Signature State NOV 04 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend I tem 23a per med cert G922 12/5/II dk State of Maryland / Department of Health and Mental Hygiene 20 | | 37376 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4Day 2019 Month Leon Frances Dawes 8:00 Medical A 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 212 West Martin Street Snow Hill Worcester If Under 1 Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Months Days Min. Hours Country) 94 **Director** 716-10-9811 /23/191 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Worcester MD Snow Hill 1 XYes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral 21863 212 West Martin Street USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Aviation Engine Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Johnny Dawes Florance Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 212 West Martin St. Snow Hill MD 21863 Lisa Cropper/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 11/7/2011 4 ☐ Donation 5 ☐ Other (Specify) First State Crem Millsboro, DE 21. Signature July vice Licensee 22. Name and Address of Facility 108 William St. mso Burbage Funeral Home Berlin, MD 21811 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Acate disease or condition resulting in death) Considery Insufficiency Medical Due to (or as a consequence of): **Examiner** Atherosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 the use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year Yes 2 No g Unknown 9 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? β Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? the Hospital or Attending Physician: The Init 24 hours after death.

the Funeral Director: After this certificate h 1 Yes 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending work? 1 Yes 2 No M ☐ Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 00063253 Clyde E. G.C. Tr. M. J.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (14+) Clyde E. Gibb JR m 428 W. Market St. Snow Hill, MD 21863 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

NOV 0

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Lucy Cuzon du Rest 12:37 P.M 28,2011 October Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Suburban Hospital Rethesda Montgomery Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours 1 □ M 2**½** F 108-18-0393 88 **Director** May Pennsylvania Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c, City, Town or Location 10d. Inside City Limits Director MD Montgomery West Bethesda 1

Yes 2 □ No the ! 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be I Funeral with t 7916 Fenway Road 20817 United States hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married by Maryland 21215-0036 If Yes, Give Year or Dates Specify: White 1 ☐ Yes 2 🔀 No Specify: Completed 3 Divorced 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working r than " life. DO NOT use retired) Ith and Mental Hygiene. 27 is marked other than r traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Editor Publishing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Gilbert Hall Theodora Stackhouse t. Page 1 and 2 should be timent of Health and Mertant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rene Cuzon du Rest/Husband 7916 Fenway Road, West Bethesda, MD 20817 Department of Health Important: If item 27 any injury or other to once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Georgetown University Medical Center 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 4 ☑ Donation 5 ☐ Other (Specify) 2011 22. Name and Address of Facility Columbia Mortuary Services, P.A. Signature of Funeral Service License /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Coronary Arteriosclerotic Disease Physician disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of: - Trans Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical requires that the death certificate be use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 🙀 No Year Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 735 autopsv nerforme death? 2 🗆 No Yes 25. Was case referred to medica of Vital 26. Place of Death (Check only one) Certificate: To Be Res examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 1 Inpatient 2 X ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Cuzondu Division 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of c 29d. Date signed (Month, Day, Year) November 2, 2011 D54776 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road Barton Walker Leonard, M.D. Bethesda, MD 20814 31. Date filed (Month Month, Day, Year) NOV 0 7 2011 State backed Registrar

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		For State Registrar	State of Maryla		artment of F rtificate of L			ne . No. 201	1 37378		
Dhysisis	n/	Decedent's Name (First, Middle, L.)	ast)				2. Date of Death	Day Year	3. Time of Death		
Physicia Medic	al	Frances Lenora			T		Wenter	04,20	1 0657 M		
Examin	er	4a. Facility Name (if not institution, g.  Meritus Medical				Location of Death		4c. County of Dea			
Funeral			Sex 7. Age (In yrs.	,,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Bi	rthplace (State or Foreign		
Director		189-20-8115 Usual Residence of Decedent	1 □ M 2 💢 F 89	Yrs.	William Bays	Tiouro IVIIII	Jan 31 1	922 Per	nnsylvania		
land show dat	tor	10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits		
28a-f		Maryland Washing	ton	Willia					1 ☐ Yes 2X No		
vith the		10e. Street and Number  16505 Virginia A	monuo Ant 12	2	10f. Zip Code 21795		10g	. Citizen of What C	ountry?		
leath v	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of Hi If Yes, specify Cuba			14. Race - Am			
after o	d by	1 ☐ Never Married 2 ☐ Married 3 🏿 Widowed 4 ☐ Divorced	1 Yes 2 X No		1 ☐ Yes 2 🛣 No		Thouli, oto.,	Black, Whi	White		
hours natura lical E	Completed	15. Decedent's			edent's Usual Occup		. 16	b. Kind of Business	s Industry		
hin 72 ne. than " e Mec	mo;	(Specify only highest Elementary/Seconday (0-12)	College (1-4 or 5+)	life. E	kind of work done of NOT use retired)						
led wit Hygie other ent, th	Ø.	12 17. Father's Name (First, Middle, Las	<u> </u>		Homemake		ne (First, Middle, Mai	ler own h den Surname)	ome		
d be fi Mental arked atic ev	မှ	William Francis	Rockwell			Mary H	Pearl Wils	on			
shoul		19a. Informant's Name/Relationship					al Route Number, Ci				
and 2 Health tem 2 other 1		Maryanne Recher  20a. Method of Disposition		Place of Disp	Box 235 osition (Name of		org, Maryl	<u>.and 2178</u> c. Location - City o			
Page 1 nent of int: If i		1 $\square$ Burial 2 $X$ Cremation 3 4 $\square$ Donation 5 $\square$ Other (Spe	☐ Removal from State cify) H		matory or other plac own Crema			,	n, Maryland		
permit. Page 1 and 2 should be filed within 72 hours after death with the Mayland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  Beginnstant: If them Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice	ensee	2	2. Name and Addres	ss of Facility M	innich Fur	eral Hom	e		
70 = 80		23a. Part Enter the disease, or co	7					wn, Mary	1and 21740 Approximate		
hysician/		shock, or heart failure. List only immediate Cause (Final	one cause on each line.		-			FIDER	Interval Between		
Medical Examiner		disease or condition resulting in death)	a. PRUDABLE  Due to (or as a consec	quence of):	7(3.60	01/1/0	Z = 1 + -	C ( )/2-0			
	er	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):									
ecuted and I-transit	Examin	cause. Enter Underlying Cause (Disease or iinjury that initiated events	200 10 (0) 40 4 00/100/								
execuian an	_	resulting in death) Last	Due to (or as a consec	quence of):							
cate be physic the bi	edica		d								
ending anding use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr 1 ☐ Live Birth 2 ☐ Fe		Ectonic pregnanc	. V		23d. Date of d	elivery		
death the att	/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of 9 Unknown		Other (specify)			Month	Day Year		
hat the ed by detack	by Ph	Part II. Other significant conditions	contributing to death but not re	sulting in the	underlying cause giv	ven in Part I.	23e. Did tobac	co use contribute t	o the cause of death?		
quires t	ed b		OBSTRUCTIO			ARY	1 🗆 Yes	2 🗆 No 3 🗀 I	Probably 4		
law rec nas ber 2 shc	Completed	PLEASE	ner KRZ(F	102 ~	. (4		24a. Was an autopsy	prior to	utopsy findings available completion of cause of		
icate h		25. Was case referred to medical	1		CO. FI	(D. II (O)	performe	d? death? No 1 ☐ Ye	es 2 🗆 No		
ysiciai s certi: directo	To Be	examiner?  1  Yes 2  No	Hospital:	ER/Outpatie	044	ace of Death (Checer: $4 \square$ Nursing He	ome 5 $\square$ Residenc	e 6 ☐ Other (Spe	cifv)		
ing Ph titer th uneral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	of 28c. Injury work	y at ?	28d. Describe how				
Attend death ctor: A y the f	Certificate:	2 ☐ Accident Investigat 3 ☐ Suicide 6 ☐ Could no	t be 28e Place of Injury - At h	nome, farm, st		Yes 2 ☐ No	28f. Location (Stree	t and Number or R	ural Route Number		
tal or / rs after al Dire ed in b		4 ☐ Homicide determine	building, etc. (Speci		,		City or Town, S				
To the Hospital or Attending Physician: The law requires that the death certificate be exwirin 24 hours after death.  To the Luneral Director After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the buria	Medical	(Check 2 Medical Exa	hysician: To the best of my know miner: On the basis of examinati	on and/or inves	stigation, in my opinio	on, death occurred a	t the time, date and p	lace, and due to the	cause(s) and manner stated.		
To the within To the comple	Σ	29b. Signature and title of certifier	urse Practioner: To the best of r	ny knowledge,	29c. License			use(s) and manner a . Date signed (Mon			
		•	to mo		12 (	8019	^	rov (D	(2011		
U-10		30. Name and address of person wh	o completed cause of death (Ite	m 23a) (Type,	Print)	5 -7 2	AKERS	1000	202174		

JW-10 State

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Certificate of De Registrar	ath	Reg.	No.	1 3/3/
Physicia	an/	Decedent's Name (First, Middle, Last)		Date of Death     Month	ay Year	3. Time of Death
Modical Exami	ner		y, Town, or Location of Deat	November 4	, 2011 4c. County of Death	0935 hrs
			gerstown	''	Washington	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Inder 1 Year If Under 24Hr	s. 8. Date of Birth(	MM/DD/YYYY) 9. Birtl	nplace (State or
Director		234-44-2868 <sub>1 M 2</sub> X <sub>F</sub> 84 <sub>Yrs.</sub> Mo	nths Days Hours Mir	July 7,	1927 Foreign	West West
		Usual Residence of Decedent		1		
w any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Maryland 28a-f show	ē	Maryland Washington County Smithsburg		Lan		1 Yes 2 No
Mary r 28a	Director	10e. Street and Number 22517 Leitersburg-Smithsburg Rd	Zip Code 21783	10g.	Citizen of What Coun	try?
hours after death with the Maryland "natural", or items 23a or 28a-f sho Examicer must be sotified at soce			edent of Hispanic Origin? ( S	nacify Vac or Na	14. Race - Americ	oon Indian Plack
ath w	Funeral	1 Never Married 2 Married Armed Forces? If Yes, sp	ecify Cuban, Mexican, Puerto		White, etc.	all ilidiali, black,
Rer de		1 Yes 2 No 3 X Widowed 4 Divorced If Yes, Give Year 1 Yes	2 No specify:		Specify: Whi	te
11215-0036 Id be filed within 72 hours after fental Hygiene. narked other than "natural", evect, the Medical Examiner.	d b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usi	ual Occupation (Give kind of		6b. Kind of Business/Ir	ndustry
2 = 2	lete	Elementary/Secondary (0-12) College (1-4 or 5+) School Ca	working life. DO NOT use ref afeteria Cook		Board of E	ducation
withir iene. Medi	Completed	12 Benoor G				ducation
21215-0036 July be filed within 7 Mental Hygiene. marked other than c evect, the Medical	BeC	17. Father's Name (First, Middle, Last) Herbert Hamrick		e (First, Middle, Mai Perkins H		
			ess (Street and Number or			Zip Code)
MD d 2 sho lith and n 27 is	-	Terry L. Davis-son 304 Sout	h 2nd Ave. Ap	ot 312 Hi	ghland Par	k, NJ 08904
ore, MEss 1 and 2 soft Health as If item 27 her traum.		20a. Method of Disposition 1		Date 2	Oc. Location - City or	Town, State
imore, MD 2 Pages 1 and 2 shoument of Health and I		A Donation 5 Other Specify: Removal from State Rose Hill Ce	metery 11-	-7-2011	Hagerstown	, MD
Baltimore, permit. Pages I ar Department of Her Important: If ite		21. Signature of Funeral Service Licensee 22. Name a	and Address of Facility			
_ ==== <u>/</u>			Eastern Blvd			
Physician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mod failure. List only one cause on each line.	le of dying, such as cardiac	or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and
≟xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Complications of Left Hip Fracture  Due to (or as a consequence of):				Death
		b				
	Je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examiner	(Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):		· · · · · ·		
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760, cate be executed physician and the burial - transit	Medical	UNPENDED AMENDED				
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Box 687 e death certific the attending I	Si	past 12 months?  1 Live birth 2 Fetal dea 4 Pregnant at time of death 5 Other (S	_	aricy	Month Da	ay Year
Box 687  ne death certific  the attending I  hed for use as the	Physician	1 Yes 2 No 9 Unknown 9 Unknown				
- T 20			ing cause given in Part I.		cco use contribute to the 2 No 3 Proba	
ords, P.C. w requires that as been signed t	Completed by	Hypertension; Dementia; Atrial Fibrillation		24a. Was an		
ord aw rec as bec	ple			autopsy performe	prior to co	opsy findings available ompletion of cause of
Rec The 1 icate h	50			1 Yes 2		2 No
1 of Vital Reco liog Physiciae: The law After this certificate has funeral director, page 2 s.	B	25. Was case referred to medical examiner?	26.Place of Death (Check		-: C Ob	
Pbys Prad di	은	1 Ves 2 No Inpatient 2 ER/Outpatient 3 27. Manner of Death 28a. Date of Injury 28b. Time of Injury	DOA Vale 4 Nursii  28c. Injury at Work?	28d. Describe how	sidence 6 Other:	
ion c teodiog eath. tor: Aft the func	Ö	1 Natural 5 Pending Oct 30, 2011 0800 hrs	1 Yes 2 ✓ No	Subject fell fra		
Division of Vital Records, tal or Atteodiog Physiciae: The law requir rs after death.  *I Director: After this certificate has been steel in by the funeral director, page 2 should the fine of the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director.	fical	2 🗹 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fact	ory, office building, etc.		et and Number or Run	al Route Number, City
Dital o	Certification:	4 Homicide determined (Specify) Nursing Home		or Town, State 10114 Sharpsbu	rg Pike, Hagerstow	n, MD
Divis  To the Bospital or At within 24 hours after d To the Fuoeral Direct completely filled in by	1	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at				
Division To the Hospital or Atteod within 24 hours after death To the Fuoeral Director:	Medical	one 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.				
	2		29c. License number  O.C.M.E.	1.	9d. Date signed (Moni	
		( Calorleill)	O.O.IVI.E.	1	November 5, 201	1
IW-20	Ì	'ae-Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimo	ore Street, Baltimore.	MD 21223		
	ate	31. Date filed (Month_Day Yeas) 32. Registrar's Signature				
Regist	rar	NOV-0 9 2011 Annual for	Get .			
DHMH 17 Rev 1/20	001	OCME ORIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 37380 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ October 7:35 pm Edith Carolyn Eckenroth 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hillhaven Assisted Living Facilities Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days 227-44-0243 1 □ M 2 🗓 F **Director** 94 12/28/1916 Pennsylvania Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many events. 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 X No Silver Spring Montgomery Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20904 13804 Overton Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11, Marital Status Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🗓 No Specify: If Yes, Give White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) **2** Elementary/Secondary (0-12) Retail/Healthcare Accountant/Business Owner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Loie Kellam Reuben J. Stalker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13804 Overton Ln., Silver Spring, Maryland 20904 Edith E. Gates - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 X Removal from State 11/06/2011 | Falls Church, Virginia National Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licenses mesher anx 11800 New Hampshire Ave., Silver Spring, MD 20904 M01524 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final > Physician/ End Stage Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Examiner Due to (or as a consequence of) Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buris Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month Day Year 5 Other (specify) Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Failure to Thrive 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Osteoarthritis autopsy performed' within 24 hours after death.

To the Funeral Director, After this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Assisted Living examiner? 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) ည 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Perturing Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 [ only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9055 Chevrolet Drive, #100, Ellicott City, Maryland 21042 Njide Udochi, M.D. 31. Date filed (Month, Day, Year) State

Registrar

NOV 04 2011

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 37382 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ANCHE 2344M TTINGER 2011 10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 2542 Sandy Run Ct. Annapolis <u>Anne Arundel</u> Social Security Number Age (In yrs. last birthday, 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗷 F Months Days Min. (Month, Day, Year) 11/16/1922 089-16-1027 **Director** 88 Usual Residence of Decedent J. Hygiene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2542 Sandy Run Ct. 21401 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes XX No ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes XX No Specify. White 3 🗓 Midowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ College Professor Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mental H Julius Mittman Miriam Ullman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Sara Schmerling Daughter 510 Post Oak Rd. Annapolis, MD 21401 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Wellwood Cemetery 4 Donation 5 Other (Specify) 11/2/2011 Farmingdale, NY Signature of Funeral Services icensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) PL Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Day Pregnant at time of death 1 Yes 2 Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 10. 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral is 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier npleted cause of death (Item 23a) (Type, Print) NN APOLG MALIYOI 445 ICHAEL DEFENSE 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 0

DHMH 17 Rev 7/2009

Registrar

1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ oct. 2011 Kenneth Fletcher Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince Georges Thomas Moore Nursing 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) /22/195 1 🔀 M 2 🗆 F Months Hours Min. **Director** 246-88-1472 59 Usual Residence of Decedent 10a. State 10b. County 1 and 2 should be filed within 72 hours after death with the Manyland of Health and Mental Hyglene.
The marked other than "natural", or items 23s or 28s-f shootiem 27 is marked other than "natural", or items 23s or 28s-f shootiem 27 is marked other than "natural", or item 27 is marked other than "natural". 10c. City, Town or Location Director MD Prince Georges Hyattsville 10e. Street and Number 10g. Citizen of What Country? Funeral 4922 LaSalle Road 20783 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Government Correction Officer Property of the Contract of the Contra Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Page 1 and 2 should be file ment of Health and Mental H ant: If item 27 is marked o Lloyd Fletcher Ethel Coples 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vera Burney/Sister 30th St. Mt. Rainier, MD Important: If item any injury or other 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State permit. Page Department Chesapeake 11/8/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Latney's Funeral Home, Inc. . Signature of Funeral Service Licensee cc0278 3831 Georgia Ave. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ a HUMAN IMMUNODEFICIENCY PIRUS 1 AIDS End Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) and Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): burial physician Physician/Medical Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ ate has been signed by the atte page 2 should be detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chamic Hidney Disease Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Dementia autopsy certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide Investigation

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

37383

1:25 PM

Birthplace (State or Foreign Country)

Black

20712

Approximate Interval Between

Onset and Death

40-ars

Year

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

City or Town, State)

Weensburgfel Hyattsville MD

10d. Inside City Limits

1 XYes 2 No

To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director. After this certificate completed filled in by the funeral director, pag Division

Medical

6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NOV 04

29a. Certifier (Check

DHMH 17 Rev 7/2009

State

Registrar

🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First\_Middle\_Last) 2. Date of Death Physician/ Albert Gabriel Fiorill October 29, 2011 ам 6:59 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 195-24-0577 96 Director 1 ₹M 2 □ F Nov. 19, 1914 PA 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD Montgomery North Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 12104 Sheets Farm Road 20878 IISA items death 1 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Black, White, etc ō þ 1 Never Married 2 Married 1 X Yes 2 □ No
If Yes, Give
Year or Dates. 1941-45 Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify. White "natural", 3 X Widowed 4 Divorced Specify: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Nicolas Fiorill Maria Nicole Catarino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 s it of Health If item 27 Maria Kohlerman/Daughter 12104 Sheets Farm Road, North Potomac, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ō 1 Burial 2 Cremation 3 Removal from State Nov. 5, Department of Important: If any injury or Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2011 21. Signature Funeral Service Licens . Name and Address of Facili Francis J. Collins Funeral Home 500 University Blvd. W., Silver Inc. Spring MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ no Ome disease or condition resulting in death) Cardiac Arrhythmia Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): B Exami The law requires that the death certificate be executed Bilateral Pleural Effusion that initiated events resulting in death) Last Due to (or as a consequence of 3 attending physician for use as the buris 11 Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Right Hip Fracture Status Post Fixation, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Coronary Artery Disease 24a. Was an page 2 autopsy certificate 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 X Yes 2 No မ 1 XInpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 2X Accident 3 Suicide 10/25/11 1 Tes 2 No Investigation 6 Could not be 3:30 got out of bed and fell 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number, City or Town, State) 299 Hurley Ave determined at rehab. center Rockville, MD 20850 Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse ractitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 20+1 D62435 Oct. 29, 2011

State Registrar 31. Date filed (Month, Day, Year) **NOV 0 4 2011** 

Sayed Elsayyad, MD

10110 Molecular Drive, Rockville, MD 20850

ed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ IAM HENRY FINLEY ITR OCTOBER 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ECI BEI VIDERE ROAD PORT DEPOSIT 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ₹ M 2 □ F Days (Month, Day, Year, Months Hours Country) 191-44-1708 56 Director á 195/ Pennsylvania Usual Residence of Decedent 10b. County ms 23a or 28a-f sho must be notified at 10a. State 10c. City. Town or Location Director Maryland Cecil Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1505 Belvidere Road 21904 U.S.A. HENRY 12 Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married If Yes, Give 1973-74 Year or Dates. 1 ☐ Yes 2 No Specify. White Specify: Completed 3 Widowed 4 Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Three Rivers Stadium (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12)
Twelve Years College (1-4 or 5+) Pittsburgh, Pennsylvania Maintenance Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 14 Mary Lou Penburgh William Henry Finley, Sr. INLEY WILL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2002 Clipper Park Road, Suite 108, Baltimore, MD (Guardian) Roseann Kirby Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other pla Garrison Forest 20c. Location - City or Town, State Owings Mills, 1 A Buria! 2 Cremation 3 Removal from State 11/09/11 4 ☐ Donation 5 ☐ Other (Specify) MaryIand Cemetery Signature of Funeral Service Lie Lee A. Patterson & Son Funeral Home, Perryville, Maryland 21903-0766 inproces M. fatterson of 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ COPD disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Pregnant at time of death 5 Other (specify) Unknown signed by the page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No has this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate; To Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Manner of Death

Natural the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred After work? 1 ☐ Yes 2 ☐ No 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Accident Investigation Could not be Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11-2-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Pint) 2.4/VA ERNANDEZM. . VA MARYLAND HEALTH CARE SYSTEM, PERZY POINT HD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

10d. Inside City Limits

Approximate Interval Between

Onset and Death

Day

1 🗌 Yes 2 🏻 No

7:07 AM

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **GEORGE** MERLE GRIMES NOVEMBER Medical 4:48 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 200 DUKE STREET STEVENSVILLE QUEEN ANNE'S 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 💢 M 2 🗆 F Director Days 218-30-0811 09/18/1934 MARYLAND Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits QUEEN ANNE'S STEVENSVILLE 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? Funeral 200 DUKE STREET 21666 UNITED STATES 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?
1 ☐ Yes 2 📉 No 14. Race - American Indian, ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black, White, etc. If Yes, Give 1 Tes 2 X No Specify: 3 🔀 Widowed 4 🗆 Divorced Completed WHITE 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 OWNER BAR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ CHARLES ELLSWORTH GRIMES BEULAH AMELIA STALLINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID MERLE GRIMES / 200 DUKE STREET, STEVENSVILLE, MD 21666 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20c. Location - City or Town, State CHESAPEAKE CREMATION 11/08/2011 STEVENSVILLE, MD Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Simul Tancous Immediate Cause (Final disease or condition Physician/ Myocardial Medical resulting in death) Due to (fr as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? ∐ Live Birth ટ∟ા reાસા પહ્સા □ Pregnant at time of death 23d. Date of delivery Yes 2 No Month Day Year 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Diubetes Mellitus, uncontrolled 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown pheral vascular disease 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed To Be 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home this 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manney f Death : After t Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 1 atural 28c. Injury at 28d. Describe how injury occurred 5 Pending injury To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At work? Accident Suicide Investigation 6 Could not be 2 🗌 No 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 115 Sallitt Drive, Suit Stevensville, MD 21666 31. Date filed (Month, Day, Year) 32. Registra's Signature

DHMH 17 Rev 7/2009

Registrar

8 2011

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			For	State of Ma	aryland		rtment of H		nd Mental Hy		20		37387
	Dhysisis	/	Registrar  1. Decedent's Name (First, Middle, La.	st)		Oei	incate or b	Catri	2. Date of D			201	3. Time of Death
	Physicia Medic	cal	ANNIE  4a. Facility Name (if not institution, give	N.	(	GOMILI	4b. City, Town, or	Location of	Month		c. County of [	0//	9:31 pm
	Examir	ier	DOCTORS HOSPITA	,			LANHAM	Location of	Death		RINCE (		RGE'S
	Funeral Director		5. Social Security Number 6. S 578-30-0563	ex 7. Age	95	birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. 8. Date of B Min. Month, D MARCH	irth lav, Year) 24	1916 N	. Birthp Count NOR I	olace (State or Foreign try) TH CAROLINA
	show dat	'n	Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Loc	ation					1/	0d. Inside City Limits
	Maryla 28a-f otified	irect		GEORGE'S	DIST	RICT	HEIGHTS						1 X Yes 2 No
	vith the 23a or st be n	Funeral Director	10e. Street and Number  1308 FAIRFIELD D	RTVE			10f. Zip Code 20747			10g. C	Citizen of Wha A	it Count	try?
036	ild be filed within 72 hours after death with the Maryland Mental Hygiene. narked other than "natural", or items 23a or 28a-f sho iatic event, the Medical Examiner must be notified at	Completed by Fune	11. Marital Status  1 □ Never Married 2 □ Married  3X Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates.	ver in U.S.	If	las Decedent of His	n, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)		14. Race - A Black, V Specify:	White, e	etc.
2-C	2 hour "natur edical	plete	15. Decedent's E (Specify only highest gr	ducation		(Give k	ent's Usual Occupa ind of work done di		of working	16b.	Kind of Busin	ess Ind	dustry
Maryland 21215-0036	vithin 7 giene. er than the Mo	Com	Elementary/Seconday (0-12)	College (1-4 or 5	+)		NOT use retired) SEKEEPER		-	l F	PRIVATI	Ξ	
nd.		To Be	17. Father's Name (First, Middle, Last)	(ADDITAL					's Name (First, Middle	e, Maider	n Surname)		
ary E	2 should be file th and Mental I 27 is marked o traumatic eve		WILLIE WALTER 1  19a. Informant's Name/Relationship (7)		T	19b. Mailin	g Address (Street a		or Rural Route Numb			a. Zin C	Code)
	C + + + +		CAROLYN ROBINSON							-			RYLAND 2074
Baltimore,	Page 1 nent of int: If it		20a. Method of Disposition 1		cem	etery, crem	sition (Name of atory or other place EMETERY		Date 11/10/11	LAN	NDOVER,	, MAR	RYLAND
Ball	permit. Pag Departmen Important: any injury once,		21. Signature of Funeral Service Licen	700					J. B. JE ROAD HYATT				AND 20785
. 4	Prrysician/ Medical		23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line	20	, «							Approximate Interval Between Onset and Death
	Examiner			Due to (or as a	s consequen	ce of):	stimas	13/6	eeding				
	ed sit	Examiner	Sequentially list conditions, if my leading to kinnediate cause. Enter Underlying Cause (Disease or linjury	Due to lor es a	te	لاتما	ney f	cail.	ure				
	be executed sician and burial-transi	al Exa	that initiated events resulting in death) Last	Due to (or as a		ce of):						$\dagger$	
200	certificate be nding physic use as the b	ledical		I d	-(1.0)							$\perp$	
Box 68		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of Live Birth 1 Pregnant at g Unknown	2 🗌 Fetal d	eath 3 🗌	Ectopic pregnancy Other (specify)	4			23d. Date of Month		ery Day Year
IS, P.O.	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  Until Defended and the Funeral Director. After this certificate has been signed by the after completed filled in by the funeral director, page 2 should be detached for	ρ	Part II. Other significant conditions	ontributing to death bu	ut not resulti	ng in the u	nderlying cause give	en in Part I.					e cause of death?
or vital Records,	The law req ate has bee page 2 shou	Completed								opsy formed?	prior deat	r to con th?	osy findings available inpletion of cause of
Ta Ta	certifica rector, I	Be	25. Was case referred to medical examiner?  1  Yes 2  No	Hospital:			10	r'	(Check only one)				
OI V	g Physical this	te: To	27. Manner of Death	1 Inpatie	y 28	l/Outpatien lb. Time of injury	28c. Injury	4 □ Nun	sing Home 5 Res 28d. Describe			(pecify	
ion	ttendin death. tor: Aff the fur	Certificate:	1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not b	n				Yes 2 1		<b>10</b>			
DIVISION	ital or Ai irs after al Direc led in by		4  Homicide determined	28e. Place of Inju building, etc		e, tarm, stre	et, factory, office		28f. Location City or To			r Hural i	Route Number,
	the Hosp hin 24 hou the Fune appleted fil	Medical	(Check 2  Medical Examonly one) 3  Certifying Nur	sician: To the best of r iner: On the basis of ex se Practioner: To the b	amination ar	nd/or invest	gation, in my opinion eath occurred at the	n, death occ time, date a	urred at the time, date	and place he cause	e, and due to e(s) and manne	the cau er as sta	use(s) and manner stated ated.
D	No No No No No No No No No No No No No N		29b. Signature and title of certifier	-	,~~	9		250	1881	11	ate signed (M	11	
R	_4		30. Name and address of person who mukemilabole ila	completed cause of de	eath (Item 23	(Type, P. <b>170. ρ</b> C)	lis Rd.,	Suito	229, Giei	nn I	Dale, 1	ND	. 20769
	Sta Registra		31. Date filed (Month, Day, Year) NOV 0 8 2011	32. Registra	r's gnatur	ails					,		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month November 20117:30p M Edythe R. Gaines 4c. County of Death 4a. Facility Name (if not institution; give street and number) 4b. City, Town, or Location of Death Prince George's Heartfields at Bowie Senior Care Bowie If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Min. Months Hours 1 □ M 2 🏝 F 227-18-6149 88 March 04,1923 Richmond, VA Usual Residence of Decede 10d. Inside City Limits 10c. City, Town or Location 1X Yes 2 □ No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20018 United States 1387 Adams Street N.E. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced **Black** Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Postal Service Distribution Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eliza Bigger James Wallace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1387 Adams Street N.E. Washington, DC 20018 Samuel T. Gaines/ Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 11-9-2011 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate

Department of Health ar Important: If item 27 is any injury or other trau once. Physician/ Medical **Examiner** attending physician Division of Vital Records, P.O. Box 68760

has

this certificate

after death. Director: After

within 24 hours a

funeral

To the Hospital or Attending Physician:

Physician/

Examiner

Funeral

Director

or 28a-f show notified at

items 23a or ner must be n ō

ed other than "natural", or ite event, the Medical Examiner

th and Mental Hygiene.
It is marked other than traumatic event, the Me

Director

Funeral

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Completed

Be

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within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Medical

10a. State

DC

shock, or heart failure. List on	y one cause on each line.			Interval Between Onset and Death
Immediate Cause (Final disease or condition	Cardio Pulmonary Fa	ailure		Onset and Death
resulting in death)	Due to (or as a consequence of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Dementia  Due to (or as a consequence of):			
Cause Clies or injury Cause (Disease or injury that initiated events resulting in death) Last	c. HTN  Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Ves 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1  Live Birth 2 Fetal death 3 Ecto 4  Pregnant at time of death 5 Othe 9 Unknown	pic pregnancy rr (specify)	23d. Date Mont	of delivery h Day Year
Part II. Other significant condition Depression	s contributing to death but not resulting in the underly	ing cause given in Part I.	23e. Did tobacco use contrib	ute to the cause of death?
Arthritis			autopsy pri	ere autopsy findings available for to completion of cause of ath?  Yes 2 No
25. Was case referred to medical examiner?		26. Place of Death (Check of		
1 Ves 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other: 4 K Nursing Hom	e 5 Residence 6 Other	(Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident Investiga	tion M	28c. Injury at work? 1  Yes 2 No	d. Describe how injury occurred	
3 Suicide 6 Could n 4 Homicide determin		ctory, office 28	Bf. Location (Street and Number City or Town, State)	or Rural Route Number,
(Check 2 Medical Ex	Physician: To the best of my knowledge, death occurriaminer: On the basis of examination and/or investigation Jurse Practitioner: To the best of my knowledge, death	n, in my opinion, death occurred at the	ne time, date and place, and due t	to the cause(s) and manner stated
		OO+ Liesman mumb en	00 1 D-t	

DHMH 17 Rev 06-2011

State Registrar gause of death (Item 23a),(Type, Print)

Name and address of person who completed

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Michael Anthony	/ Ga	arvin 1- For State Registrar	State	of Maryla		artment o	f Health ai f Death	nd M	lental Hy	_	eg. No. 2	01	1 3738
Physici		1. Decedent's Name (First							1	2. Date of Dea Month		ar	3. Time of Death
Medical Exami	ner	MICHAEL ANT			nher)	Г	4b. City, Town, o	r Loca	ation of Death	Novembe	r 9, 2011 4c. County		0000 hrs
1		135 Watkins Sta			noer y		Gaithersbu		ation of Death		Montgo		
Funeral		5. Social Security Number	6. Se:	x	7. Age (In yrs.	last birthday)	If Under 1 Ye	_	Under 24Hrs.	8. Date of Bi	rth (MM/DD/YYY)		Ihplace (State or
Director	١.	138-52-4503	1 🔀	M 2 F	52	Yrs	Months Da	ys   F	Hours Min.	04/22	/1959	Foreig	ountry) PA
any		Usual Residence of Dece 10a. State 10b. C			10c. City	. Town or Local	tion						10d. Inside City Limits
<b>.</b>	Ļ	MD Mo	ntgame:	rv	1 1	thersbu							1 X Yes 2 No
farylar 28a-f s	Director	10e. Street and Number					10f. Zip Code			1	0g. Citizen of W	hat Cou	ntry?
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once		135 Watkins	Stati	on Circ	le, #C		20879				USA		
th with	uneral	11. Marital Status 1 Never Married 2	Married	12. Was Dece Armed For	dent Ever in U		as Decedent of H es, specify Cuba					e, etc.	ican Indian, Black,
ter dea	Ŀ		_	1 Yes If Yes, Give Year	2 No	1	Yes 21 N			,	Specify:	Wh	ite
ours af Atural	d by	15. Decedent's Education		or Dates:	completed)		nt's Usual Occup	ation (0	Give kind of wo		16b. Kind of Bu		
7	lete	Elementary/Secondary	(0-12)	College (1~	4 or 5+)		ost of working lif			d)			
5-003 led withi Hygiene. other th	Completed	11th 17. Father's Name (First, I	Middle Last)			Pnone	Technic			First Middle I	Commur Maiden Surname		tions
215.	BeC	Thomas Garv							ary Lea		Watuett Suttlattie	,	
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umartic event, the Medica	၉	19a. Informant's Name/Re									nber, City or Tow		
		Kiersten Gaz 20a. Method of Disposition		augnter			2 Grack			ltnersi Date	burg, MI		
Baltimore, I Demit. Pages 1 and Department of Heal Important: If item		1 Burial 2 Cre	mation 3	Removal from	m State	crematory or of	her place)		1		Hanove	-	
Baltimo permit. Page Department or Important: injury or oth		4 Donation 5 Ot 21. Signature of Funeral S		ee P	ALC	/					uneral H		
Dep Dep B		Lenge	T	Acros	eclen	15.6					kville,		
Physician /Medical		23a. Part I. Enter the disea failure. List only one	se, or compli cause on eac	cations that cau th line.	used the death	o not enter t	he mode of dying	, such	as cardiac or r	espiratory arre	est, shock, or he	art	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final d or condition resulting in de	sease a. (	Cirrhos: Oue to (or as a c	is of I	iver							Death
		Sequentially list conditions		Chronic									
	iner	if any, leading to immediat	e D	ue to (or as a c	onsequence o	f):							
d d	Examiner	(Disease or injury that initi events resulting in death)		ue to (or as a c	onsequence o	f):						_	
ox 68760, eath certificate be executed attending physician and for use as the burial - transit	dical	X UNPENDED	d	AMENDED 2	3a-b.2	7.per m	e,g921 1	1-2	29-11 s	m			
60, ate be e hysicia e buria	Medi	IF FEMALE:			itcome of preg						23d. Date of	deliven	,
687 ertifica ding p	an/	23b. Was decedent pregna past 12 months?	nt in the	1 Live birt	th	2 Fe	tal death 3	Ec	ctopic pregnanc	у	Month		Day Year
Box 68760 the death certificate is the attending physical for use as the bh	Physician/Me	1 Yes 2 No 9	Unknown	9 Unknow	nt at time of de n	eath 5 Ot	her (Specify)						
P.O. E es that the digned by the		Part II. Other significant of	onditions	contributing to c	leath but not re	esulting in the u	nderlying cause	given i	in Part I.	23e. Did to	bacco use contri	ibute to	the cause of death?
ords, P.C	ed by	-				-			_			Prob	ably 4 V Unknown
cords, law requir has been s	plet						-			24a. Was a autop	sy p	prior to c	topsy findings available ompletion of cause of
Rec The 1	Completed									1 Yes		death?	s 2 No
Vital Rec hysician: The this certificate	å	25. Was case referred to mexaminer?	Ho	ospital: 1 Inc	patient 2	ER/Outpatient		_	eath (Check on		Residence 6	Other	Scene
ding Phy	٤	1 Yes 2 N	)	28a. Date of (Month, D	Injury	28b. Time of li					now injury occurre		· Occins
rtendin feath, stor: A	atio	1 Natural 5 2 Accident	Pending Investigation		ay, routy		10	Yes 2	2 No				
Division of Vital Records, pital or Attending Physician: The law requirences after death.  The Inrector: After this certificate has been sifilled in by the funeral director, page 2 should be a shoul	Certification:	3 Suicide 6	Could not be determined	9	of Injury - At ho	ome, farm, stree	t, factory, office	ouildin	g, etc. 28	or Town, St		er or Ru	ral Route Number, City
Tospita 4 hours		4 Homicide 29a. Certifier 1 Certify		n: To the best of	of my knowledg	ne death occur	red at the time of	ate an	d place and di	e to the cause	e(s) and manner	as state	ad
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	Medical		Examiner:		examination a						and place, and d		
HSHS	M	29b. Signature and title of					29c, Licens				29d. Date signe		
	Į	his	nu	, >			O.C.	M.E.			November	10, 20	111
		<ol><li>Name and address of p Ling Li, MD Ass</li></ol>				,	e Street, Bal	timor	re, MD 2122	23			
			7 2011										
Regist	rar	NUV I	1 2011	Seneu	w p.	gave							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 0:00 M Gardner Robert Lester Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Meritus Medical Center Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) **X**M 2 □ F 8/17/1939 Maryland **Director** 72 218-38-1549 h "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Hagerstown MD Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21740 434 North Prospect Street death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed Specify: White 3 Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Custodial Custodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Baughman Cora James Η. Gardner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21348 Ruble Road, Boonsboro, MD 21713 .0 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Rhoda Stotelmyer / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Hagerstown, Maryland 11/11/2011 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner May Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of). Exami The law requires that the death certificate be executed and -tran Due to (or as a consequence of): burial attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Day Month Year 1 ☐ Yes ≥ L 9 ☐ Unknown the P.0. signed by the Part II. **Other significant conditions** contributing to deat<del>a but n</del>otiresulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 onknown Completed Were autopsy findings available prior to completion of cause of page 2 s has autopsy death? Yes Hospital or Attending Physician: ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 -NO 1 Thipatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 A Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed on (Item 23a) (Type, Print)

State Registrar

TW-7

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Pau1 Gordon 3:45a Irving 5, 2011 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis La Plata Center La Plata Charles 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Sept. 25, 1936 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 X M 2 □ F 75 577-52-8118 MĎ Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be neithed at 10a. State 10b. County 10d. Inside City Limits MD Mechanicsville Funeral Director St. Mary's 1 ☐ Yes 2 🔼 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20659 USA 26506 Tin Top School Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xo Specify: Specify: White Completed by 3 ☐ Widowed 4 🙀 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than Union Local #602 Steam Fitter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be of Health and Mental Frances Coughlin Cecil Gordon ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10468 Mark Drive., Waldorf, MD 20601 Cathy Stewart - Daughter Department of Health Important: If item 27 any Injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 11/10/11 Alexandria, VA Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Raymond Funeral Service, P.A. 21. Signature of Funeral Service Licensee M00641 Joseph Barton Yates per DVR 5635 Washington Ave., LaPlata, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician theumania disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Companyle Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed Medical alter burial-trar Due to (or as a consequence of) Box 68760 physician Physician/Medical the aftending ph IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗌 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) P.0. 9 Unknown signed be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 1 □ Yes 2 □ No 3 Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ,≰utopsy performed′ Physician: The No Yes 2 □ No 1 ☐ Yes ; After this certification is funeral director, i 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Man er of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Injury 1 V Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

le Funeral Director; / 2 Accident 3 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi within 2. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 1A 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 22 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ WILLIAM STANLEY HARRIS JR OCT 2011 10:18 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY BETHESDA WRNMMC If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months 1**x** M 2 □ F Balt Md 77 03/19/1934 219-30-2161 Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland must be notified at Director XX Yes 2 No Md. Prince George's Bladensburg 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 23a 5802 Annapolis Road # 710 20710 U.S.A. filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. the Medical Examiner Armed Forces?

14 Yes 2 No
If Yes, Give Korean
Year or Dates. War If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ŏ δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 'natural", Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Map Maker/Dept.of Defense U.S. Government other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) r is marked of t. Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked ည William Stanley Harris, Sr. Edna Rudwall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Hazel O. Harris/Wife 5802 Annapolis Rd. #710,Bladensburg,Md. 20710 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location ~ City or Town. State Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/04/11 Beltsville Maryland Chesapeake Crematory, Inc. 22. Name and Address of Facility Henry S. Washington & Sons Co., Inc. Signature of Funeral Service Licensee and 4925 Burroughs Ave., N.E., Washington, D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ♣No 3 ☐ Probably 4 ☐ Unknown 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an the Hospital or Attending Physician: The law thin 24 hours after death.

the Funeral Director: After this certificate has be autopsy performed? Yes 2 No filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 🏋 No Be 26. Place of Death (Check only one) Hospital Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural iniury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) NOV, 1, 2011 VA 0101248380 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD TIDA KUMBALASIRI LT 20889 5600 WRNMMC, BETHESDA, MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Houdersheldt Eugene Robert Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Allegany Cumberland WMHS-RMC If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)

WV **Funeral** Age (In yrs. last birthday) 8. Date of Birth Days 1 XM 2 F Jul 29 **Director** <u> 233-70-0321</u> 67 28a-f shov 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Oldtown MD Allegany 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23aFuneral 14109 Cresap Mill Rd. SE 21555 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⅓ Yes 2 ☐ No If Yes, Give Year or Dates. Vietna 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. 0 2 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", Specify: Completed 3 Widowed 4 Divorced Vietnam white the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Diesel Mechanic U.S. Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked o permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked any injury or other traumatic eve ည Mary Lee Ridgeley Noah Ellis Houdersheldt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14109 Cresap Mill Rd. SE Oldtown MD 21555 Nancy Houdersheldt wife 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation Rocky Gap Veterans Cemetery 3 Removal from State 11/9/201 MD Flintstone Donation 5 Other Specify) ignature f Funeral Service 22. Name and Address of Facility and Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician considered: the Lung. a. Adeno disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of. as the burial-transi Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical requires that the death certificate be Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 Yes 2 No ed by the a Division of Vital Records, P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 24 hours after death.
Funeral Director, After this certificate has leted filled in by the funeral director, page 2 s autopsy perform 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\subseteq\) Nursing Home 5 \(\subseteq\) Residence 6 \(\subseteq\) Other (Specify) Hospital: 2 No ည 1 KInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Funer

completed fil 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 12 who completed cause of death (Item 23a) (Type, Print) . 12502 Willowbrook Rd. Ste. 440 Cumberland, MD 21502 100 M.D Zaman Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

NOV 08 2011

banks

11-08384

amend 23a, 27, per me, g923 1-12-12 sm Please Type or Print in Black Indelible ink, Ensure All Copies Are Legible.

Gene Pierre Hop		1- For State Registrar	State of M	aryland		rtificate			wient		Re	eg. No.	201	1 3739
Physicia Medical Exami		Mon							Date of Deat Month November	Day	Year	3. Time of Death 1207 hrs		
ALLAN,		4a. Facility Name (if not institution, give street and number)						4b. City, Town, or Location of Death			TTOTOTION	4c. Co	unty of Death	3
805 Langley Di								er Spring		0.411	0.0.1.100		tgomery	(0)
Funeral Director	217-42-4125 1AM 2DF 66			ast birthday)  If Under 1 Year If Under 24Hrs.  Months Days Hours Min.  Yrs.			8. Date of Birth(MM/DD/YYYY) 9. Birthplace (Stat Foreign Country) DC			on l				
any	ō	Usual Residence of Decederation 10a. State 10b. Co.			10c. City,	, Town or Loc	ation							10d. Inside City Limits
<b>E</b>		MD Montgomery Montgomery Village								1 Yes 2 No				
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with the Maryland ns 23a or 28a-f sho be notified at once.		18925 Mills		Dad, ‡		S 113 V		886 lent of Hispa	anic Origi	n? (Spe	cify Yes or No	USA 14	Race - Amer	ican Indian, Black,
leath w	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White						White, etc.						
ral", o	Completed by	3 Widowed 4 Divorced of Specify: 1 Yes 2 X No specify: Specify: B							ecify: Bla					
2 hours		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  MD Nat							apital Pk &					
0036 within 72 hours after death with the Maryland jene. her than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once		12th			Sani	Sanitation Worker					Planı	ning C	commission	
우등뜻들회		17. Father's Name (First, M									First, Middle, N		name)	
ID 21214 should be fill and Mental Fi if is marked natic event, i	To Be								r Town, State	e, Zip Code) 20910				
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic ex	[	Patty J. Hop	· · · · · · · · · · · · · · · · · · ·	9										ring, MD
or Heal		20a. Method of Disposition  1 Burial 2 X Crer		ioval from S	tate	Place of Disp crematory or	other plac	∍)			Date		ation - City or	,
Baltimore, permit. Pages I ar Department of Hei important: If ite nijury or other tr		4 Donation 5 Otr 21. Signature of Funeral Se	ner Specify:		Arc						4/2011 wden Fi			
Bal permi Depar Impo injur		George Snowd		/R							st, Ro			
Physician		23a. Part I. Enter the disea failure. List only one of	se, or complications	that caused	d the death	. Do not ente	r the mode	of dying, si	uch as ca	rdiac or r	espiratory arre	est, shock,	or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final di	sease a. Athe	rosc1	eroti	c Car			_	-	_	•		Death
or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.														
	iner	if any, leading to immediate cause. Enter Underlying C	Due to	or as a cons	sequence o	of):								
- i	xam	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):												
O, be executed sician and burial - transit	edical Examiner		d											
60, ate be ex hysician e burial		IF FEMALE:	23c.	If yes, outco	me of preg	inancy	_				-	23d. Da	ate of deliver	y I
OX 6876 eath certificate eath certificate eath certificate for use as the I	ian/l	FEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   1 Live birth   2 Fetal death   3 Ectopic pregnancy   Month   4 Pregnant at time of death   5 Others (Specific)								Day Year				
Box e death c the atten ed for us	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  Nonth  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month  1 Other (Specify) 9 Unknown  2 Other (Specify) 9 Unknown  2 Other (Specify) 9 Unknown  2 Other (Specify) 9 Unknown  2 Other (Specify) 9 Unknown							1 kl						
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on of Vital   ending Physician: ath. rr: After this certifi he funeral director,	o Be									r: Scene				
<b>ट</b> इं . ` द	Ë	27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 2 Accident 2 Place of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred							now injury o	occurred				
Division tal or Attendii ars after death.	licati								Number or Ru	ural Route Number, City				
The street of th								30	or Town, State)					
Di To the Hospital within 24 hours a To the Funeral	Medical (	Z98 CB(IIIB)   a value at the second of the control												
To th To th		29c.License number					29d. Date signed (Month, Day, Year)							
DOME								Novem	ember 9, 2011					
	3. Name and address of pers. In who completed cause of death (Item 23a)  Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223													
	ate	Theodore M. King 31. Date filed (Month, Day						. Baitimo	ore Stre	et, Bai	umore, ML	J Z 1ZZ3		
SI Regis		MOV 17	2011		. 1	ure par								

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend 25 per med cert G921 11/30/11 dk
State of Maryland / Department of Health and Mental Hygiene

		1	For State Of IVIa		rtificate of Dea			ene eg. No. 2 1 1	37395			
	Physicia		1. Decedent's Name (First, Middle, Last)  Florence Louise HOUSE				2. Date of Death Month November	3. Time of Death 12:50 a.M				
	Medic Examin	al .	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death			4c. County of Deatl					
-	Examin	EI	207 High Street	Hagerstow		Washington						
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 🗷 F 7. Age		Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day, March 1	9. Birthplace (State or Foreign Country) 111,1920 Penna.					
	and show I at	l 1	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location         10d. Inside City L									
<b>036</b> rs after death with the Maryla	Maryk 28a-f otified	To Be Completed by Funeral Dir	Maryland Washington		Hagersto	wn	1 X Yes 2					
	s 23a or		10e. Street and Number 207 High Street		10f. Zip Code 21740			0g. Citizen of What Co USA	untry?			
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent E Armed Forces? 1 Yes 2 Married 15 Yes, Give Year or Dates.	No	Was Decedent of Hispar If Yes, specify Cuban, M 1 ☐ Yes 2 🔀 No S		ecify Yes or No- o Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: white					
15-0	72 hou n "natu ledical		15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during OO NOT use retired)	n ng most of workin	ng	16b. Kind of Business	Industry			
212	within giene. er thar the M		Elementary/Seconday (0-12) College (1-4 or 5	+)	:lerk		deli					
land	be filed vertiled by the lental Hygricked other lice event,		17. Father's Name (First, Middle, Last) William Swails	18.	18. Mother's Name (First, Middle, Maiden Surname) Pearl Deck							
Baltimore, Maryland 21215-0036	12 should alth and M 27 is ma r trauma		19a. Informant's Name/Relationship (Type, Print)  Charles House – husband				al Route Number, City or Town, State, Zip Code) agerstown, Maryland 21740					
	age 1 and ent of Hee nt: If item y or othe		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		matory or other place)			20c. Location - City or Hagerstown				
Baltir	permit. P Departm Importar any injur		A Donation 5 Other (Specify)  Rest Haven Cemetery 11/11/11 Hagerstown, Maryland  21. Signature of Funeral Service Librase  22. Name and Address of Facility MINNICH FUNERAL HOME  415 E.Wilson Blvd., Hagerstown, Md. 21740									
~~/ <sub>6</sub>	Phy⊾i∈ian/	0.1	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition  Approximate Interval Between Onset and Death  (1574)									
	Medical Examiner		resulting in death)  a. Due to (or as a consequence of):									
s, P.O. Box 68760 res that the death certificate be executed	ted nsit	ıminer	Sequentially list conditions, it any, touching to immediate cause. Enter Underlying Cause (Disease or linjury	emater	il arthre		1974					
	e be execu iysician and ie burial-tra	edical Examiner	that initiated events resulting in death) Last  C. Due to (or as a d.	a consequence of): Usal Va	d arthu		1997					
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of delivery Month Day Year					
	ires that the signed by d be detack	Medical Certificate: To Be Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?									
Division of Vital Records,	he law requ te has beer age 2 shou		Dyslystemi  Dentetts mellitus type 11 mild  24a. Was an autopsy performed? 1 yes 2 No 3 probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death? 1 yes 2 No 1 yes 2 No 1 yes 2 No									
tal	sian: T ertifica ctor, p		25. Was case referred to medical a company 26. Place of Death (Check only one)									
ξ	Physic this c		1   Yes 20X No   1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)									
o uc	ath. r: After		1 Natural 5 □ Pending (Month, Day, Year) injury work? 2 □ Accident Investigation M 1 □ Yes 2 □ No									
Division	al or Atte s after de il Directo		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	e Hospit 24 hour e Funera		29a. Certifier (Check (Check only one)  1									
	To th within To th		29b. Signature and title of certifier  Mashub		29c. License nu			29d. Date signed (Month, Day, Year)				
U	is all	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  MASSOUD B. ALIZADEH 240 Fuederack SA Hagors Town MD 21740  31. Date filed (Month, Day, Year)  32. Resistrar's Signature										
t	W-6		M4550 UD B. ALIZADE A  31. Date filed (Month, Day, Year)	2 40 Ru ar's Signature ●	ederich St	Hago	Sived n	MO 2174	0			
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registro	wa B. x	Bark							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37396 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Frank Italia 8:50 pm November 01.2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince George's Renaissance Gardens - Riderwood Silver Spring 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** New York 1 X M 2 🗆 F Months Days Hours (Month Day, Min **Director** 054-05-2304 Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City Town or Location 10d. Inside City Limits Director 1 Yes 2 V No Silver Spring Maryland Montgomery 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country's Funeral with 3114 Gracefield Road, #516 20904 u.s.A. items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. ò ģ 1 Never Married 2 Married 1 X Yes 2 If Yes, Give Year or Dates 2 No Navu Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 'natural", Specify: Completed 3 X Widowed 4 Divorced White. WWII the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Department of Defense Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other traumatic eventore. 2 Nicolo Italia Francesca Cascio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12508 Carry Back Place, Gaithersburg, MD 20878 Raymond Italia - Son 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Lincoln Mausoleum 11/07/2011 4 Departion 5 De Other (Specify Entembment Brentwood, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nset and Death
Years Immediate Cause (Final Physician/ Conjestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** 20 Years <u>Coronary Heart Disease</u> Sequentially list conditions, if any, reading to immediate cause. Enter Underlying -transit Examir or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Chronic Kidney Disease 10 Months Due to (or as a consequence of) resulting in death) Last g physician and street purial-t Physician/Medical Box 68760 nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy signed by the atte in the past 12 months? Day Pregnant at time of death Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy page performed? 2 No Yes 2 Y No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 X No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 X Nursing Home 5 Residence 6 Other (Specify) 4 hours after death.

uneral Director: After this ed filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a

To the Funeral C

completed filled To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 10 41 address of person who completed cause of death (Item 23a) (Type, Print) Maryland 20904 3110 Gracefield Road, Silver Spring, CRNP Harding.

DHMH 17 Rev 7/2009

State

Registrar

2. Registrar's Sig

2011

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		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location		4c. County of Death							
Funera		Montgomery General Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Olney  If Under 1 Year If Un	nder 24Hrs. 8. Date of Birt	Montgomery th(MM/DD/YYYY) 9. Bird	h-1 (Ct-1						
Directo		214-69-9639 1 M 2 F 34	Months Days Hou			hplace (State or n nezuela						
any		Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Lo				10d. Inside City Limits						
Aaryland 28a-f show	ğ	MD Montgomery Germa	ntown			1 Yes 2 No						
h the Mar 3a or 28a	Director	10e. Street and Number 13015 Robins Nest Terrace	10f. Zip Code 20874	10	Og. Citizen of What Cour Venezuel	•						
e, MD 21215-0036  I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.  Health and Mental Hygiene are "matural", or items 23a or 28a-f sho rivamantic event, the Medical Examiner must be notified at once.	=	11. Marital Status  1 Never Married 2 X Married  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 X No  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 X No	Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica Vene X Yes 2 No specify	an, Puerto Rican, etc.) zuelan	White, etc.	White						
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nore, MD 21215-0036 sgss 1 and 2 should be filed within 72 hours af int of Health and Mental Hygiene. itt filem 27 is marked other than "natural other traumatie event, the Medical Examinal	Be Co	Juan Carlos Infante	Z	er's Name (First, Middle, M aida Elena	Sulbaran							
MD 2 d 2 shoul 1th and M n 27 is m	٩	Julia Infante/Wife   1511 Baylor Avenue Rockville, Md.										
5 8 4 H 3		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, 1 Burial 2 X Cremation 3 Removal from State crematory or other place)										
	ii.	4 Donation 5 Other Specify: Chesa	peake Crem.	11/16/201	1 Beltsvi	lle,Md						
Balt permit Depart Impor		July Danier 9	HYPTETPAdpessRifter 241 Columbia	MLDI FUNER a Blvd.Sil	AL SERVIC ver Sprin	E,P.A. g,Md20910						
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760, cate be ophysicia	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		20 12 Sm	23d. Date of delivery							
Division of Vital Records, P.O. Box 68760, To the Bopital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/	4 Pregnant at time of death 5	Fetal death 3 Ectopi Other (Specify)	ic pregnancy	Month Da	ay Year						
P.O. B s that the de gned by the		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in P	art I. 23e. Did tob	pacco use contribute to the	ne cause of death?						
S, P.( quires that en signed ald be deta	ed by			1 Yes	2 ✓ No 3 Proba	bly 4 Unknown						
Records, The law requir, icate has been si	Completed			24a. Was ar autops perform	y prior to co ned? death?	ppsy findings available mpletion of cause of						
tal Rec cian: The certificate ector, page	Be Co	25. Was case referred to medical	26.Place of Death	1 Yes 2	No 1 ✓ Yes	2 No						
of Vital  ig Physician: After this certi	10 E	examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie  27. Manner of Death  28a Date of Injury  28b Time of Injury  28b Time of Injury		Nursing Home 5 R								
ion of ttending Pi leath. tor: After the funera	ation:	27. Manner of Death  1 Natural 2 X Accident  28a. Date of Injury (Month, Day, Year)  1 Investigation  1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 Von 2 Ter		ow injury occurred took cocair	ne						
Divis pital or A ours after of eral Direction by	Natural   Suicide   Accident											
To the Hosp within 24 ho To the Func completely f	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurrence)  Wedical Examiner: On the basis of examination and/or investig	curred at the time, date and pla	ace, and due to the cause(	(s) and manner as stated	Cause(s)						
	£	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Monti	h, Day, Year)						
5-per	1	30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		November 12, 201	1						
		Donna M. Vincenti, MD Assistant Medical Examiner 90	0 W. Baltimore Street,	Baltimore, MD 212	23							
St Regis		31. Date filed (Month, Day, Year)  NOV 1 7 2011  32. Registrar's Signature										

Physic Med Exam

Funera Directo

State		,			Mental Hy	gierie		0 7 0 0				
Registrar	1	Cer	rtificate of De	eath		Reg. No. 2	011	3739				
1. Decedent's Name (First, Middle, Last)		ON TD			2. Date of Dea Month NOVEMBE		2Ŏ11	3. Time of Death 2:55 PM				
JOSEPH ANTHO  4a. Facility Name (if not institution, give s		ON, JR.	4b. City, Town, or Lo	ocation of Death	HOAFIDE		unty of Death					
202 SPANIARD NECK				EVILLE		QUEEN ANNE'S						
5. Social Security Number 6. Sex		e (In yrs. last birthday)	If Under 1 Year	f Under 24 Hrs. Hours Min.	8. Date of Birt	h	9. Birth	hplace (State or Foreign				
213 20 1111	<b>X</b> M 2 □ F   {	<b>33</b> Yrs.	Months Days	I Iours	NOV. 21,			IARYLAND				
Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Loc	cation					10d. Inside City Limits				
MD QUEEN AN	NE'S	CENTREV	ILLE				1 Yes 2 X No					
10e. Street and Number			10f. Zip Code		10g. Citizen	of What Cou	untry?					
202 SPANIARD NECK	ROAD		216	517			USA					
11. Marital Status	ecify Yes or No- Rican, etc.)		Race - Ameri Black, White									
1 ☐ Never Married 2 🗶 Married 3 ☐ Widowed 4 ☐ Divorced	16	ITE										
15. Decedent's Edu		946-1947 16a. Deced	dent's Usual Occupati	on		16b. Kind o	of Business/li					
(Specify only highest grad Elementary/Secondary (0-12)	de completed) College (1-4 or 5	(Give I	kind of work done dur O NOT use retired)	ing most of work	ring	100111110	, 200000					
12	3		FARMER			FARM	ING					
17. Father's Name (First, Middle, Last)	CT C C		1	8. Mother's Nam			ame)					
JOSEPH ANTHONY JA					RIE McDA							
19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  202 CDANTADD NECK DOAD CENTREVILLE MD 21617												
BETTY A. JACKSON/ WIFE 202 SPANIARD NECK ROAD, CENTREVILLE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of pate 20c. Location - City of pate 20												
1 X Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)		GREENMOUN	NT CEMETER	1	11,2011							
21. Signature of Funeral Service License	-		2. Name and Address	of Facility								
Cl e.	+K/	/ . FE	TTOUC TIET	TENTO DETAIL	C BITTET TATA	M CTINE	PAT H	OME D A				
		40	ILLUWS, HELLI 18 S. LIBE	TY ST.	CENTRE	VILLE.	MD 2	OME, P.A. 1617				
23a. Part 1. Enter the disease, or compli shock, or heart failure. List only one		the death. Do not ente	18 S. LIBE	RTY ST.,	CENTRE	VIIIIE,	MD 2	Approximate Interval Between				
shock, or heart failure. List only one Immediate Cause (Final disease or condition	e cause of each line	the death. Do not ente	er the mode of dying,	RTY ST.,	CENTRE	VIIIIE,	MD 2	Approximate				
shock, or heart failure. List only one Immediate Cause (Final	a. Due to (or as a	the death. Do not enter	OS LIBE	such as cardiac	CENTRE or respiratory and	VIIIIE,	MD 2	Approximate Interval Between				
shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	e cause of each line  a.  Due to (or as a	the death. Do not enter  SPNE A  consequence of):  6C CHROA	OS LIBE	such as cardiac	CENTRE or respiratory and	VIIIIE,	MD 2	Approximate Interval Between				
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io the

Registrar

DHMH 17 Rev 06-2011

State

Medical

29a. Certifier (Check only one)

ERIC F.

29b. Signature and title of certifier

31. Date filed (Month Day, Year) 2011

CIGANEK,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M/D.

32 Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

629 RAILROAD AVENUE, CENTREVILLE, MD 21617

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2125 M Vasilios Kopsidas November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital 9. Birthplace (State or Foreign Country)
Greece If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

June 20, 1939 Social Security Number . Age (In yrs. last birthday) **Funeral** Min. 1 **X** M 2 □ F 219-64-0473 Director 72 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director Silver Spring 1 Yes 2 X No Montgomery Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a t any originry or other traumatic event, the Medical Examiner must be once. Funeral U.S.A. 20904 14000 Colesville Manor Place 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🗶 No If Yes, Give þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Business Owner Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Evdoxia Kopsidas Nikolaos Kopsidas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14000 Colesville Manor Place, Silver Spring, MD 20904 Argyro Kopsidas - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗓 Burial 2 🗌 Cremation 3 🗌 Removal from State 11/07/2011 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funcial Service Linensee M00209 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear dailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Proviician/ Neuroendocrine Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner V  $K \rho \rho Si daS^{11}/2 hon aldS$ Records, P.O. Box 68760 Sequentially list conditions. if any, leading to immediate
Cause (Disease or linjury Examine Due to (or as a consequence of): the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Vaar Pregnant at time of death Other (specify) been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law r 24 hours after death. Funeral Director: After this certificate has b page 2 s autopsv performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 🛣 No ျာ 1 🗷 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: work? 1 Yes 2 No iniurv 5 Pending 1 X Natural Investigation Accident 2 Accident
3 Suicide
4 Homicide 6 Could not be within 24 hours after de
To the Funeral Directo 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 03, 2011 D0063195 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

DHMH 17 Rev 7/2009

NOV 04 Registrar

Steven Wilks, Date filed (Month, Day, Year) 8600 Old Georgetown Road, Bethesda, Maryland 20814

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Bernard James Kitten October 31, 9:40 p M 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Chesapeake Anne Arundel Arnold 8. Date of Birth (Month, Day, Year) Jan. 9, 1924 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 🖾 M 2 🗆 F 193-24-9175 87 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1279 Seabright Drive 21409 Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? 1 ☐ Yes 2 ☒ No 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: White ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Bernard Kitten, Sr. Anna Louise Stark ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn Reedy/Daughter 1279 Seabright Drive Annapolis, MD 21409 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Baltimore, MD 4 Donation 5 Other (Specify) Signature of Fundani Service Licenses 2. Name and Address of Facility Premation Direct 495 Ritchie Hwy. Severna Park, MD 21146 2 /a art 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or modition resulting death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, Clease or no that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à No 3 Probably 4 Unknown 26rovasala 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To A Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Physician** /Medical Examiner Physician: The law requires that the death certificate be executed Box 68760. P.0. Division of Vital Records, al or Attending P safter death. I Director: After d in by the funera To the Hospital of within 24 hours at To the Funeral D

**Funeral** 

Director

"natural", or items 23a

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinations.

and

attending physician a for use as the burial-

signed by the a

page 2 should

funeral director,

Medical

(Check only one)

29b. Signature and title of certifier

has

certificate

After

Baltimore, Maryland 21215-0036

death with the Maryland la or 28a-f show t be notified at

State Registrar

30. Name and address of pellon who completed cause of death (Item 23a) (Type, Print) May Mullersoulle, MD 21108 8601 Veterans 31. Date filed (Month, Day, Year) NOV 0 3 2011 32. Registrar's Signature park

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D57531 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 37401 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Carroll Milton Koslowski Sr.  $201^{\circ}$ October 0 11:15a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Homestead of Sun Valley Carrol1 Sykesville Social Security Number 8. Date of Birth (Month, Day, Sept 5 6 Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 214-14-0848 1 X M 2 □ F 90 Director 1921 MD or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD Carrol1 Sykesville 1 Yes 2 No 10e. Street and Number 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? 21784 6410 Bonnie Brae Road USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?

1 X Yes 2 If Yes, Give
Year or Dates. Black, White, etc. ö Completed by 1 Never Married 2 Married 2 No WWII 1 ☐ Yes 2 ☐XNo Specify. Specifywhite "natural" 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene.
item 27 is marked other than
other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) defense contracting production supervisor Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Fred Koslowski Emma Gallion 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6410 Bonnie Brae Rd., Sykesville, MD 21784 Department of Health an Important: If item 27 is any injury or other traus Diana Schaefer (daughter) timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XBurial 2 Cremation 3 Removal from State Meadowridge Memorial 11-1-11 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Raight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Harge Harght P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to large a consequence of sician and burial-transit death certificate be executed Due to (or as a consequence of): resulting in death) Last the attending physician IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral irector, page 2 should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗌 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes Accident Investigation 6 Could not be 2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month) WIL 6+1VA (Item 23a) (Type, Print) 2300 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ O4 Day 11:25 AM TROTHY MAE KENNELL 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death-4c. County of Death **Examiner** CUMBERLAN DEVLIN MANOR ALLEGAN Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months (Month, Day, Year) 1 🗆 M 2 🖫 F Hours Country) OH Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director CUMBERLAND ALLEGANY 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 tems 23a 10301 USA 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. and Mental Hygiene. is marked other than "natural", or 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: White 3 Midowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOME MAKER injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ permit. Page 1 and 2 should be i Department of Health and Ments Important: If item 27 is marked Scritchfield LeMasters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Pickett Duffy 70094 Deloris St. Waggaman Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Sunset Memorial Cumberland MD 2011 4 Donation 5 Other (Specify) 169 Clarence 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hyndman PA Harvey H. Zeigler FHINC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Wante disease or condition Medical Examiner resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) sician and burial-transit that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical 68760 as the l IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box ( 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No jo Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Records, 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 Yes 2 No Yes 2 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Other: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Norming Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this ocmpleted filled in by the funeral dil 27. Manner of Death 28b. Time of 28c. Injury at 28a. Date of injury (Month, Day, Year) Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Division 1 Yes 2 🗌 No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death Territory in the basis of examination and/or investigation, in my opinion, death Territory in the basis of examination. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗋 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FROSTBURG MD 21532 JESUS H. TAN MD 4 S. BROADWAY 31. Date filed (Month, Day, Year) NOV 08 2011 32. Registrar's Signature State

Registrar
DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ reples Month Day 1904 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GENELL HUSPITA 00054 MONTOOMER MONTGOMERY Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Hours Min. 389-14-9935 Director 1 **X** M 2 □ F 88 Jan. 23, 1923 WT Usual Residence of Decedent show ms 23a or 28a-f sho must be notified at 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10g, Citizen of What Country? Funeral 3422 Chiswick Court 20906 USA Department of Health and Mental Hygiene Innormant of Health and Mental Hygiene Innortant; If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 11. Marital Status 14. Race - American Indian. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Yes. Give Completed 3 🔀 Widowed 4 🗌 Divorced WWII Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Auditor Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Stella Engelhart Joseph Koehler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet A. Boyce/Daughter 322 Abbey Road, Berwyn, PA 19312 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Nov. 9 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 4 □ Donation 5 ☒ Other (Specify) entombmen 2011 Silver Spring, MD permit. Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. Li Interval Betweer Immediate Cause (Final Onset and Death < Physician/ ARRHYTHULA disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial frams resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Yes 2 No 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy performed? Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

•To the Funeral Director: After this certificate is completely filled in by the funeral director, page 2 No Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 / No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work?
1 Yes 2 No Accider
Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Configure Nurse Practitionary of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 15+1 00070274 201 11 MD

DHMH 17 Rev 06-2011

State

Registrar

30. Name a

ASON

NOV 07

31. Date filed (Month, Day, Year,

PRINCE

lywp

OLYEM

20832

ddress of person who completed cause of death (Item 23a) (Type, Print)

tsio i

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
Amend 25 per med cert 6922 1278/11 dk
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Catherine Lorraine Kimble 8:14 pm Medical November 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown 5. Social Security Numbe 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Days Hours Min. April 26, 1924 Director 219-20-1682 Yrs 87 Marvland Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Maryland Washington 1 ☐ Yes 2X No Hagerstown 10e. Street and Number 10f. Zip Code Funeral 10g. Citizen of What Country? 17514 Stone Valley Drive 21740 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married Completed by Black, White, etc. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: 3 X Widowed 4 □ Divorced Specify. White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Housewife Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Russell M. Turner Blanche Catherine Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James G. Kimble, Sr. - Son 17514 Stone Valley Drive Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial Cremation Removal from State Donatio 5 Other Greenlawn Mem. Park Nov.10,2011 Williamsport, Maryland Borne Artmerality Home, P.A. 425 S. Conococheague St.Williamsport, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between On et and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of ract Infection burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and Due to (or as a consequence resulting in death) Last attending physician Physician/Medical Box 68760 the as IF FEMALE use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ō in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month the a Year 9 Unknown P.O. be detach signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available Jas page 2 prior to completion of cause of death?

1 Yes 2 No autopsy within 24 hours after death.

To the Funeral Director: After this certificate nerform Yes 2 Division of Vital or Attending Physician: filled in by the funeral director, 25. Was case referred to me Be 26. Place of Death (Check only one) examiner? 2 X No Other: မ 1 Npatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? Accident Investigation Μ 1 Tes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier npleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and titl 144996 Ompleted cause of death (Item 23a) (Type, Print) Cappans Rd Boonsboro MD 21713

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Monti

egistrar's Signature

11-081	12
Brigitte	Long

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

te Long		1- For State Registrar	_	and / Depart <i>Certii</i>	ment of ficate of		Mental F	Re	g. No. 201			
Physicia ical Exami		Brigitte Long						2. Date of Death Month October 28		3. Time of Death 1850 hrs		
		4a. Facility Name (if not institution 1473 Crofton Parkway	. •	umber)	4	b. City, Town, or L Crofton	ocation of Deat	h	4c. County of Deat Anne Arunde			
Funeral Director		5. Social Security Number 215–52–9419	6. Sex	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hr Hours Mi	n	(MM/DD/YYYY) 9. Bi Fore: 28, 1943			
w any		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Location					10d. Inside City Limits		
Maryland 28a-f sho	Director	10e. Street and Number	ARundel			Croftc 10f. Zip Code	n 114	1 Yes 2 N 10g. Citizen of What Country? U.S.A.				
permit. Pages 1, 19.  Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Di	1473 Crofton  11. Marital Status  1 Never Married 2 Ma	12. Was De	cedent Ever in U.S. orces?		Decedent of Hisp	anic Origin? ( §			4. Race - American Indian, Black,		
rs after dea aral", or it	by		1 Yes	2 X No er	1		specify:		Specify: What 16b. Kind of Business	White		
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be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be Con	wille Bayn						18.Mother's Name (First, Middle, Maiden Surname) Hermine Caska				
d 2 should lith and Mei n 27 is man	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Roll Richard B. Long – Son  40 Heritage Way, Naples,								cida 34110			
permit. Pages I and Department of Heal Important: If iten injury or other tra		20a. Method of Disposition  1 Burial 2 Cremation  Donation 5 Other Sp.		rom State cres	matory or oth	tion (Name of ceme er place) rematory		Date -2-2011	20c. Location - City o			
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nysician Medical xaminer	Ż	23a. Part I. Enter the disease, or of failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)	on each line. a. Atheroscle	rotic Cardiovas			uch as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death		
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leath certificate e attending phy for use as the b	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No 9  Unki	e 1 Live b	nant at time of death	2 Feta	al death 3 [ er (Specify)	Ectopic pregr	nancy	23d. Date of delive Month	ry Day Year		
ires that the d signed by the	ğ	Part II. Other significant condition		o death but not resu	Iting in the ur	nderlying cause giv	ven in Part I.		pacco use contribute to	the cause of death?		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Completed							24a. Was a autops perform	y prior to ned? death?	utopsy findings available completion of cause of		
hysician: this certifical director, p	å	25. Was case referred to medical examiner?  1 ✓ Yes 2 No	Hospital: 1	Inpatient 2 EF	VOutpatient		of Death (Check		Residence 6 🗸 Othe	er: Scene		
tal or Attending Phy rs after death. al Director: After th led in by the funeral or	tion: To	27. Manner of Death  1  Natural 5 Pendi	28a. Date (Month		Bb. Time of In		at Work?		ow injury occurred			
: Hospital or Attend 24 hours after death 5 Funeral Director: stely filled in by the	Certification:		not be	e of Injury - At home	e, farm, street	, factory, office bu	ilding, etc.	28f. Location (S or Town, St		ural Route Number, City		
To the Host within 24 ho To the Func completely f	Medical C											
	ž	29b. Signature and title of certifier		MI		29c. License O.C.M			29d. Date signed (Microber 29, 201			
3	1	30. Name and address of person of Russell Alexander MD.	. Assistant N	ledical Examin		V. Baltimore S	Street, Balti	more, MD 212	23			
St Regist	ate	31. Date filed (Month Pay Year)	011 32 Re	egistrar's Signature	back	, ,						

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 37406 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ George Marsh Landis November 2011 7:15 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death La Casa Assisted Living Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** (Month, Day, Year) **Director** 230-14-2360 1 🗶 M 2 🗆 F July 17,1924 Washington, D.C Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Maryland| Anne Arundel 1 🗆 Yes 2 🙀 No West River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4312 Charles Gift Court 20778 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 A Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 9 within 72 hours after If Yes, Give Year or Dates W. W. II 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene.
s marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Public Safety 12th Firefighter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental H George Samuel Landis Georgia Beatrice Fowble 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) age 1 and 2 sh nt of Health au t: If item 27 is Deborah J. Judy/ Daughter 4312 Charles Gift Ct., West River, MD 20778 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Page 1 8 Department of 1 Durial 2 X Cremation 3 Removal from State injury Kalas Crematory 11/4/11 4 Donation 5 Other (Specify) Edgewater, Maryland 21. Signature of Funefal Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical that the death certificate be for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 1100 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) LIND Other: မ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work s after death. 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral L Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day, Year)

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

**Division of Vital** 

705 Digital Drive, Linthicum, MD 21090

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

NOV 0 4 2011

Arvind Desai,

31. Date filed (Month, Day Year

		_ For	'lease	State of		and / De	partme	ent of I	lealth a		II Copie: ental Hy		-	<b>).</b>	
		State Registrar  1. Decedent's Name (First, A	Aiddle, La	st)			ertifica	te of L	Death		2. Date of Dea	Reg. N	201	1	3740
Physicia Medic		Paul B. Lath	e	,							Octobe	D	9 2011 Year	1	:47am M
Examin	er	4a. Facility Name (if not instituted as 3565 Cemeter			nber)			y, Town, o s <b>tmin</b>	r Location of	f Death	4c. County of Dea				
Funeral		5. Social Security Number	6. S	Sex	7. Age (In yr.	s. last birthda		der 1 Year	If Under 2	24 Hrs.	8. Date of Birl	9. B		e (State or Foreign	
Director		215-42-6726 Usual Residence of Deceder		X M 2 □ F	68	Yrs	ivioritis	S Days	Hours	IVIIII.	077317	194	3	ountry)	Md.
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h with t ns 23a nust b	Funeral Director	3565 Cemet	ery I	Lane				211			USA				
er deat or iten niner r	by Fu	11. Marital Status 1 ☐ Never Married 2 ☐	Married	12. Was Dece Armed Fo		U.S. 1	If Yes, sp	ecify Cuba	an, Mexican,	in? (Spec Puerto F	ecify Yes or No- Rican, etc.) 14. Race - Am Black, Whi				ndian,
urs affe tural", al Exar	ted b	3 Widowed 4 Dive	orced	If fes, Giv Year or Da		L.G.	1 🗌 Yes	2 No	Specify:		Specify			ite	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To B	17. Father's Name (First, Mid Bert Lathe					_	18. Mother's Name (First, Middle, Maiden Surname) Eleanor Hottle							
ind 2 shoi lealth and im 27 is n her traum		19a. Informant's Name/Rela Paula Lathe			<del></del>	362	4 Scha	alk R					d. 2110		)
age 1 a ent of H nt; If ite y or oth		20a. Method of Disposition  1 ☑ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Ot			State	Place of Discometery, of Discometery, of Par	rematory or	r other plac			ate /2011		ocation - City o		
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9 G E E 9	- 3	23a Part 1 Enter the disease		plications that o	causad the de	ath Do not				Sykes	sville,	Md.	21784.		
Physician/		23a. Part 1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition	List only o	one cause on ea	ch line.	-	30-20-3			1	MX RE		1801	Inte	proximate erval Between set and Death
Medical Examiner		resulting in death)			or as a conse	equence of):		17.25		,	7.10	-014		24	MASATTHE
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ate be ex physician the buria	g		GHT PONSIL								MONTHS				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transitions.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			Birth 2 ☐ F nant at time o	etal death	3 ☐ Ectopio 5 ☐ Other (		ey .				23d. Date of d Month	elivery Day	Year
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Attendi r death ctor; A y the fu	Certificate:	2 ☐ Accident In 3 ☐ Suicide 6 ☐ C	vestigation ould not b	e —	of Injury - At	home, farm,	M street, facto		Yes 2 1	$\rightarrow$	8f. Location (S	itreet ar	nd Number or R	ural Rou	te Number.
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Hosp 24 hou Funer leted fil	ledical	(Check 2 Medi	ical Exami	sician: To the be iner: On the bas se Practioner:	is of examinat	ion and/or inv	vestigation, i	n my opinio	on, death occ	curred at t	he time, date a	nd place	e, and due to the	cause(s	and manner stated.
To the within To the comp	Σ	29b. Signature and title of ce		A	io the best of	my knowledg		9c. License	number				ite signed (Mon		
WILVA		an No	Jan	- 400	MO	00.1		D 3	413	3		10	131/1	/	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Fern Elizabeth Lyzbicki Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Western Maryland Health System **Alleghany** Cumberland . Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Jan 24 1918 Black Twp., PA Director 93 211-07-4504 Usual Residence of Decedent shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Alleghany Corriganville 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21524 United States PO Box 3 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 No Specify: 3<sup>X</sup> Widowed 4 □ Divorced Completed 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 10 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Daisy R. Brant Norman B. Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 134 Romans Rd. Somerset, PA 15501 Dale Lyzbicki 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔣 Burial 2 🗆 Cremation 3 🗀 Removal from State 11/4/11 Somerset PA 15501 4 Donation 5 Other (Specify) Somerset Co. Mem Pk 21. Signature of Funeral Service Licensee NONTHSE 22. Name and Address of Facility KEMBY MEYERS NALE 111552 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph<sub>sician/</sub> disease or condition resulting in death) BAR Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician a the for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the same should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed 2 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: ပ္ 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation

Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 a

Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certil use of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

29a. Certifier

6 Could not be

determined

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Year Month 10/31 2:00 A Muriel Mason McCrindle Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chevy Chase Manor Care Chevy Chase Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex Funeral (Month, Day, Yea 4/2/1926 1 - M 2 XF Days Months Hours Min. Director 234-46-8187 Scotland Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 Yes 2 No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2203 42 ST NW Apt. 100 Scotland | 20007 or items Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or other traumatic event, the Medical Examiner Black, White, etc Completed by 1 Never Married 2 Married ☐ Yes 2x No Yes, Give Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2X No "natural", 3 Divorced 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) British Embassy Administrative Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Adam H. McCrindle Matilda Thomson t. Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna McCrindle Sister 2712 Wisconsin Ave Nw Washington DC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 11/04/2011 4 ☐ Donation 5 ☐ Other (Specify) National Crematory Falls Church. 22. Name and Address of Facility Joseph Gawler's Sons . Signature of Funera 5130 Wisconsin Ave NW Washington DC 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Frailty Medical Due to (or as a consequence of): Examiner Parkinson's Disease Sequentially list conditions, if any, leading to immediate cause Error Underlying Examine Due to (or as a consequence of): an and Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal deat 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 K 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place are the cause and due to the cause (s) and due to the ca

P.O. Box 68760 Division of Vital Records, within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to the funeral director, to the funeral director, to the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director is the funeral director. To the Hospital or Attending

30

(Check

29b. Signature

only one)

31. Date filed (Month, Day, Year)

and title of certifier

NOV 04 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Summit Gupta MD 100 First St. Unit 130 Rockville, MD 20851 32. Registrar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

112-31-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 31, Day 2011 Year Oct. Physician/ 7:00 A M Gertrude Elizabeth Marshall Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Deale Anne Arundel 5933 Deale Beach Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 199-16-9834 Months Davs Hours Min 87 1/13/1924 PA **Director** 1 M 2 XX 28a-f shov 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location must be notified at Director MD Deale Anne Arundel 1 Yes XX No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ö items 23a Funeral USA 20751 5933 Deale Beach RD. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2XX No Specify: If Yes, Give Year or Dates "natural", 3 XXWidowed 4 □ Divorced Completed 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. If tem 27 is marked other than "natur other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Insurance Clerk Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 은 Ada Bailey William J. Monaghan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 shart of Health a Deale, MD 20751 5933 Deale Beach Road Jacqueline Talbott Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2XX Cremation 3 Removal from State 11/1/2011 Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 70 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ATIC CARCINOMA 170/11/3 disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 t No
9 Unknown Month Day 5 Other (specify) Pregnant at time of death P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ 10 Division of Vital Records, 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performer? Yes 2 No has death?
1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Other: 4 \(\to\) Nursing Home 5 \(\textbf{X}\) Residence 6 \(\to\) Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Director: After 1 Natural 5 Pending work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: Al Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Excrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [

State Registrar 31. Date filed (Month) , Day, Year)

30. Name and address of perso, who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

32. Redistrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Monge Month 10/28 72011 Physician/ Annett 340pm M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2408 Springlake Ct. E Gambrills Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 73 215-34-1113 Director 1 M 2XXF Yrs 1/4/1938 PA show 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director r 28a-f sl notified Gambrills 1 Yes 2XX No MD Anne Arundel 6 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 21054 USA 2408 Springlake Ct. E iral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc Completed by 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 White 1 Yes XX No Specify Specify "natural", 3 Widowed 4 ☐ Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Blinded Veterans Administration Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I is marked o ပ Toy Howard Hill Geneva McCurry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health : 2408 Springlake Ct. E Gambrills, MD 21054 Andrew Mongelli 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Surial 2 Cremation 3 Removal from State Our Lady of the Fields 11/4/2011 Millersville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. Signature of Funeral Servicensee Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line 1 mtosk Immediate Cause (Final Physician/ monar 105 emo CIA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box ( 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No yes g ☐ I Dav Year Pregnant at time of death Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, The law requires 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has bage 2 s autopsy 1 Yes 2 No Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 📉 Natural 5 Pending 1 Yes 2 No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier CRV R076293 11-1-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annapolis MD21401 Gale 3 wmor 31. Date filed (Month State

DHMH 17 Rev 06-2011

Registrar

for State Registrar State of Maryland / Department of Health and Mental Hygiene 37412 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Oct. Mildred K. 2011 Marcy 31 500 Α Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Collington Assisted Living Mitchellville Prince Georges Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 04/20/1913 117-01-6709 98 1 □ M 2X F Director Oregon Yrs Usual Residence of Decede "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director MD Prince Georges Mitchellville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10450 Lottsford Road 20721 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates nit. Page 1 and 2 should be filed within 72 hours any partment of Health and Mental Hygiene.

nortant: If item 27 is marked other than "natural" Specify: White Completed 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Executive U S Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bruce Randall Kester Mabel Judd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric B. Marcy 25241 Prummond Town Rd. Accomac, VA 23301 (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 

Burial 2 

Cremation 3 

Removal from State Atlantic Crematory 11/2/2011 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Annroximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Jement 1a Sueas Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: for use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 X No 1 Yes **Division of Vital** or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of s after death. Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending work?
1 Yes 2 No Investigation Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as season.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗌 Certifying Murse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and Me of 29d. Date signed (Month, Day, Year) 2011 30. Name and a son who completed cause of death (Item. 15 Dr. William DuBoyce 31. Date filed (Month 32. Registrar's Signature State 03 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

P.0.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month NOV. Day Physician/ 2019 Peter D. Mackessy 8:20 AΜ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 14104 Heatherstone Dr. Bowie 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min (Month, Day, Year) 578-44-9006 1 🛛 M 2 □ F 76 **Director** Jun. 15, 1935 Washington DC Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City. Town or Location at Director must be notified 1 X Yes 2 No Bowie MD Prince George's 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ö 23a 20720 U.S.A. 14104 Heatherstone Drive or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2XX Married 1957 Baltimore, Maryland 21215-0036 1 Yes 2XX No Specify If Yes, Give Year or Dates 'natural", Specify: Completed 3 Widowed 4 Divorced 1959 White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Police Officer Secret Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o 2 Mary Elizabeth Moran William Mackessy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 14104 Heatherstone Dr., Bowie, MD 20720 Shirley A. Mackessy - Wife or other 20b. Place of Disposition (Name of cemetery, crematory or other place 20a, Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 🗌 Burial 2 ី Cremation 3 🗍 Removal from State Metro Crematory 11-2-2011 Baltimore, MD Bonation 5 Other (Specify) Signature of Funeral Service Line Beall Funeral Home 22. Name and Address of Facility 6512 NW Crain Hwy., Bowie, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Bleeding Physician/ year disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury and -tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical that the death certificate be Box 68760 as t IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ No} \) Pregnant at time of death the g Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 performed? Yes 2 No death? 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 No Other: 1 Tyes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: eral Director: After filled in by the funer (Month, Day, Year) 1 Natural 5 Pending death. 1 Yes 2 No Investigation Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined hours after within 24 hours a To the Funeral D To the Hospital Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 4/34 of person who completed cause of death (Item 23a) (Type, Print) Name and address 4201 Mitchellville Rd#102. MD State 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death MiglioriNi Physician/ November 1:25 Рм 20°F1 Leuis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Odenton 8615 Fluttering Leaf Trail Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Dav. Year) Days Hours Min 1**X** M 2 □ F **Director** 218-22-5941 84 Yrs 1927 Maryland Sept. 26, Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location with the Maryland Examiner must be notified at Director 1 Yes 2X No Anne Arundel Odenton MD 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? ō 23a 21113 USA Funeral 8615 Fluttering Leaf Trail items 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc "natural", or þ 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Navy Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. other than " Bureau of Engraving within 7 College (1-4 or 5+) Elementary/Secondary (0-12) the and Printing 12 Lithographer other other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or care ပ Katherine Reece Joseph Migliorini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8615 Fluttering Leaf Trail, Odenton, MD Norrine A. Migliorini-Spouse 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State Resurrection Cemetery 11/7/2011 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun ral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. eart 1. Enter the disea shock, or heart failule Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events resulting in death) Last -trar and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Pregnant at time of death the 9 Unknown been signed by to should be detach Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 1 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of has page 2 death?
1 Yes 2 No certificate Yes 2 To the Hospital or Attending Physician: 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 2 No 2 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred Certificate: Natural injury 5 Pending ☐ Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) www completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who MD 20110 Mitchellville Fa Suite 102 Canadoa

DHMH 17 Rev 06-2011

Registrar

State

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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h with	Funeral Director	11214 Day	ysville Rd.	21701						U.S.A.					
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f Healt item 2 other		George P. Misulia / son 8602 Mapleville Rd. Mt. Airy, MD 217  20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or To													
Page nent o ant: If ary or		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			emetery, cren Peter			ery   11/3	/2011	Li	berty	tow	n, MD		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service L	icensee	0				ss of Facility Ha		une	ral Ho	ome			
		23a. Part 1. Enter the disease, or	- Varia	the deat				erty Rd.			town,	MD			
Dhuninian /		shock, or heart failure. List o											Approximate Interval Between Onset and Death		
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Examiner	_	Sequentially list conditions,	b. ————												
sit sit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury													
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rtificat ling ph e as th	/Мес	IF FEMALE:	00-16												
eath certifica attending p	cian,	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Feta	aldeath 3	Ectopic pre Other (spec		У			23d. Date Month		ery Day Year		
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v requires that s been signed t should be det	by	Part II. Other significant condition	ns contributing to death b	out not res	ulting in the u	nderlying cau	use giv	en in Part I.					ne cause of death?		
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ilcian: The la certificate ha rector, page	Be Co	25. Was case referred to medical					26. Pla	ace of Death (Chec	1 \( \text{Yes} \)	2	lo 1 L	Yes	2 No		
Physician: this certific al director,	To B	examiner? 1  Yes 2 No			ER/Outpatier	nt 3 🗆 DOA	Othe	er: 4  Nursing H	ome 5 $\square$ Resi	dence	6 😾 Other (	Specify,	son's residence		
Jing P. T. Affer ti funera	ate:	27. Manner of Death  1 Natural 5 Pendin			28b. Time of injury		. Injury work	?	28d. Describe I	now inju	ry occurred				
Attend r deatl ector:	Certificate:	2	not be 28e. Place of Injuried			M eet, factory, o		Yes 2 ☐ No	28f. Location (	Street ar	nd Number	or Rural	Route Number,		
tal or as after al Director		4 - Horriciae determi	building, et	c. (Specify	")				City or Tov	vn, State	9)				
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici. To the Loneral Director: After this certificate has been signed by the after the funeral director, page 2 should be detached for use as the but	Medical		Physician: To the best of xaminer: On the basis of e												
o the lithin 2 of the lomple	Me	only one) 3 Certifying 29b. Signature and title of certifier	Nurse Practioner: To the	best of my	y knowledge, o			e time, date and pla number	ice, and due to th		s) and mannate signed (/				
WJZ		· No.	all in	Λ				3105P			1-1-		. ,		
12		30. Name and address of person v	who completed cause of d	leath (Item	23a) (Type, F	Print)					-				
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #4b&c Per PHY G922 12/08/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12:57P Physician/ Marma Morant October Medical 4a. Facility Name (if not institution, give street and number) 4b. City Fort Washington Prince Georges **Examiner** Prince Coorge's 4404 Payne Drive If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 578-50-1938 **Director** 1 M 2 X F 74 July 9, 1937 SC Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10c. City. Town or Location 10a. State filed within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at Director 1 X Yes 2 No MD Prince George's Fort Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 4404 Payne Drive 20744 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner Armed Force Black, White, etc. ò 1 Never Married 2 Married 2 **X** No þ ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: **Black** If Yes, Give Specify: "natural", 3 Widowed 4 X Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Government other than Elementary/Secondary (0-12) College (1-4 or 5+) Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I 2 Vera Biddle John Wagner Melton permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kenneth Morant/Son 4404 Payne Drive, Fort Washington, MD 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 nemoval from State Fort Lincoln Cemetery: 11/7/2011 | Brentwood, Maryland 4 Donation 5 Other (Spe 22. Name and Address of Facility Pope Funeral Homes, P.A. re of Funeral Service L 5538 Marlboro Pike, Forestville, Maryland 20746 1000 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Alzheimers Demen 7 b Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. In ter U identifing Examiner Due to (or as a consequence of) búrial-transi Cause (Disease or injury that initiated events resulting in death) Last been signed by the attending physician and Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed2 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Be 1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Certificate: To 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 5 Pending injury 1 Natural 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Worlijapalnem.D 00057 465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. 5. Ray apa KSC (M.D. 28 35 5m ) M Baltimore MD 21209-5203 N. S. Rigapa KSE, M.D

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ctoper Thleun Mack 6:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Nursing Home Clinton Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 😾 F Days Min. Months Hours Director pril 1932 247-66-8428 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Funeral Director MD Prince George's Clinton 1 XYes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ò 23a 11818 Birchview Court 20735 United States ural", or item 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 No and 2 should be filed within 72 hours after. timore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give "natural", 3 Midowed 4 ☐ Divorced Completed Year or Dates **Black** event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Private Elementary/Seconday (0-12) College (1-4 or 5+) Food Dietician 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers 2 Margaret Hubbard traumatic Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Health tem 27 Sylvia Davis-Smith/Daughter 11818 Birchview Court, Clinton, Maryland 20735 item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State It. Page 1 a
Department of H
Important: If ite 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/05/2011 Washington National Suitland, Maryland 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Servi 5538 MArlboro Pike, Forestville, Maryland 20746 23a. Pal 1. Enter the dil ease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Fina disease or condition a Line of State of Approximate Interval Between Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner erebovascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of). burial-transit Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_ Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year ned by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe this certificate 2 🗆 No Yes 2 No 1 🗌 Yes ivision of Vital To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) 1 🗌 Yes 2 🖳 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the within 2 70053337 ctober 312011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore, Mdzizora Ste Zes 2835 Smith MD Avenue

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year) NOV 0 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Month **Physician** 15 十九 Kay Morri 2011 /Medical 4a. Facility Name (If not institution, give cireet and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 13 Mary Road Mano ennett 4 Hrs. 8. Date of Birth Min. (Month, Day, Year) andi Count 7. Age (In yrs. last birthday) ial Security Number If Under Birthplace (State or Foreign Country) **Funeral** Months Days Hours Ohio 283-36-519 1939 Director Mar 4, Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location show 7 Is marked other than "natural", or Items 23a or 28a-f shov traumatic event, Ite Medical Evant are must be confined at 1 □Yes 2 □ No OH Meiss Pomeroy Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 102 Union Avenue 45769 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify. ģ 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Coal Company secretary 17. Father's Name (First, Middle, Last) CITIC: 18. Mother's Name (First, Middle, Maiden Surname) Be Virginia Evans ဂ္ Aruthur M. Hoyt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other trau Ansel Hoyt brother 1135 Fagin's Run Road New Richmond OH 45157 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 11/5/2011 Mound Hill Cemetery Gallipolis OH 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA ignature Funeral Service 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lipe. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician is be detached for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 icate has been si 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 □ Yes 2 - No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖪 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner eath 28b. Time of ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 28d. Describe how injury occurred After 1 28c. Injury at Work? n tural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2. and manner stated. 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and add ess of person who completed of ause of death (Item 23a) (Type, Print) Mas 2 othere Savopa 31. Date filed (Month, Day, Year) NOV 0 8 2011 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year McElfish Eleanor Mae 11) PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Western MD Regional Medical Center Allegany Cumberland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months **Director** 1 🗆 M 2 😾 F 214-05-7453 93 10/28/1918 Maryland Usual Residence of Decede or 28a-f show notified at 10b. County within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be Funeral 1014 Harding Avenue 21502 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. δ 1 Never Married 2 Married Maryland 21215-0036 1 Tes 2 No Specify Specify: 3 X Widowed 4 Divorced Completed White er than "natur , the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Il Hygiene. 12 Homemaker Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Taylor Richard Nora Mae Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard M. McElfish /Son 12620 Donegal Drive, Chesterfield, VA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ♥ Burial 2 Cremation 3 Removal from State Hillcrest Mem. Park 4 ☐ Propation 5 ☐ Other (Specify) 11/14/2011 Cumberland Sinnature of Funeral Service Adams Family Funeral Home, P.A. 22. Name and Address of Facility 404 Decatur Street, Cumberland, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physicson/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death 2 🗌 No 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 100 မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending 1 Natural 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month, Day, Year) per D/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month,

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Shiv C. Khanna, M.D., 1221-E National Highway, LaVale, MD

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Rogelio Mondargoi	otato or man juntar = opan arror	t of Health and Mental Hygiene e of Death	Reg. No. 2011 3742									
Physician Medical Examine	Decedent's Name (First, Middle,Last)	2. Date o	Day Year 1019 has									
ncarear Examine	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	dc. County of Death									
	8450 Dorsey Run Road	Jessup	Howard									
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign E1 Salvado: Country)									
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I	ocation	10d. Inside City Limits									
	Md. Prince Georges Hyatt	sville	1 X Yes 2 No									
the Maryland a or 28a-f show tified at once. Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?									
with the us 23a o		20783  3. Was Decedent of Hispanic Origin? ( Specify Yes	er No- 14. Race - American Indian, Black,									
r death with the Maryland , or items 23s or 28s-f sho r must be notified at once. Finneral Director	1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto Rican, etc	c.) White, etc.									
	or Dates:	Yes 2 No specifySalvadora										
2 hour "natu	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	edent's Usual Occupation (Give kind of work doneing most of working life. DO NOT use retired)	16b. Kind of Business/Industry									
5-0036 ed within 72 hours after death with the Maryland lygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once Completed by Furneral Director	3rd (	Construction Worker	Construction									
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica		18. Mother's Name (First, Mic Angel Maria	,									
2121; hould be fil and Mental F is marked ritic event, f	T	lailing Address (Street and Number or Rural Route	e Number, City or Town, State, Zip Code)									
ore, MD ss 1 and 2 sho of Health and If item 27 is her traumati		7910 18th Avenue # 212 isposition (Name of cemetery, Date	Hyattsville, Md. 20783									
Baltimore, MD 21215-0036  bernit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner To Be Completed by	1 XBurial 2 Cremation 3 Removal from State Family	or other place 11/12/20										
Baltimore permit. Pages 1 Department of F. Important: If injury or other	21. Signature of Funeral Service Dicensee 22. Name and Address of Facility											
Physician /Medical	failure. List only one cause on each line.											
Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a consequence of):		Death									
d d	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):											
e i	cause. Enter Underlying Cause (Disease or injury that inhaled  Due to (or as a consequence of):											
0, be executed sician and O burial - transit	events resulting in death) Last Due to (or as a consequence of):											
60, e be executed ysician and burial - transi	UNPENDED AMENDED											
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s, P.O. ires that to signed by do be detac			Yes 2 V No 3 Probably 4 Unknown									
of Vital Records, ag Physician: The law require. After this certificate has been signered director, page 2 should be			Was an autopsy findings available prior to completion of cause of death?									
tal Rec			Yes 2 No 1 ✓ Yes 2 No									
Vital bysician: this certif	examiner? [Hospital:	IOthor III	5 Residence 6 🗸 Other: Scene									
on of Vital Records, P.O. Box 6876( ending Physician: The law requires that the death certificate ath. or: After this certificate has been signed by the attending phys the funeral director, page 2 should be detached for use as the b	27 Manner of Death 28a Date of Jointy 28h Tim	): 1 Yes 2 ✓ No Subject	cribe how injury occurred assaulted									
ivisi or Att after de Directa Jin by	2 Accident Investigation Oct 27, 2011 1813 hr 3 Suicide 6 Could not be determined (Specify) Jail/Penal	street, factory, office building, etc. 28f. Loca or To	ation (Street and Number or Rural Route Number, City own, State) rsey Run Road, Jessup, MD									
Divi	/98 Gentiler	Homicide    Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.    Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.    Professional Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)    Professional Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)										
2	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)									
	30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	October 28, 2011									
	Carol Allan, MD Assistant Medical Examiner 900 W.	Baltimore Street, Baltimore, MD 21223	3									
Stat Registra	a 31. Date filed (Month, Day, Year) 32. Registrar's Signature	aled										

OCME

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ November 4:24 Lawrence Rucker MARTIN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown Age (In yrs. last birthday 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Month, Day, Young 1 X M 2 🗆 F Days Hours Min. Director 219-14-8654 Virginia 86 June Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location at the Maryland 10d. Inside City Limits Director must be notified 28a-f 1X Yes 2 ☐ No Maryland Washington Hagerstown 10e, Street and Number 10f. Zip Code 'n 10g. Citizen of What Country? Completed by Funeral 23a 901 Kenwood Drive 21740 USA ral", or items 2 Examiner mus permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? or. Black, White, etc. 1 Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 🗌 Widowed 4 🗌 Divorced Year or Dates 1943-46 "natural" White ed other than "natur event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Lumber Distributor if Health and Mental Hygier item 27 is marked other to other traumatic event, the Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Bessie Lee Lawrence Percy Elsom Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenwood Drive, Hagerstown, Maryland 21740 <u>Genevieve K. Martin - Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 11/11/2011 | Hagerstown, Maryland 21. Signature of Funeral Service Licens 6 Minnich Funeral Home 22. Name and Address of Facility ~ イ. E. Wilson Blvd. Hagerstown, Maryland 21740 415 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsel and Death Immediate Cause (Final and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of been signed by the attending physician should be detached for use as the burial Physician/Medical ハババ バック レベル どかじだ Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an has autopsy performe after death. Director: After this certificate by Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital or A within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Our tifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

TW-5+1 State Registrar (Check only one

29b. Signatur and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

195 . Registrar's Signature 29d. Date signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November Theodore Wayne MYERS Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 218-38-1742 1**½** M 2 □ F Sept. I1, 1940 Director 71 Mary land Usual Residence of Decedent or 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Washington Hagerstown 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 448 East First Street 21740 USA 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. "natural", or þ 1 X Never Married 2 Married 1 Yes If Yes, Give 2 X No 1 Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Specify: white Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 stockholder block company Be 17. Father's Name (First, Middle, Last) should be file and Mental F 18. Mother's Name (First, Middle, Maiden Surname) Theodore Martin Myers Helen Irene Marshall 19a. Informant's Name/Relationship (Type, Print) 1 and 2 shound Health and item 27 is m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Sneckenberger – sister 9652 Sharpsburg Pike, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 Department of I 20c. Location - City or Town, State Page 1 1 X Burial 2 Cremation 3 Removal from State any injury or cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 11/12/11 Hagerstown, Maryland Signature of Funeral Service License 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated second Examine sician and burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last physician the burial Physician/Medical use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death
Unknown Day signed by to Part II. Other significant conditions contributing to death but for resulting in the pinderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 2 🗆 No Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No မ 1 Yes Other: 1 Inpatient 2 🗌 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? within 24 hours after death.

To the Funeral Director: Afcompleted filled in by the fu 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

JW-15 State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Registrar

29b. Signature

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

strar's Signature

29c. License number

10045001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 9011 Kathryn Louise Myers 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death If Under Dear | If Under 24 Hrs. vavenwood uthar Village Washington Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Months Days Hours 1 □ M 2 🛛 F Pennsylvania 89 1922 217-18-7952 Jan.15, Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 □Yes XXNo Maryland Washington Williamsport 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 16603 Buford Drive USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2/CX If Yes, Give Year or Dates: 1 Never Married 2 Married 2XNo 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Retail Dress Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martha Isabell Stine Preston Milford Kendle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21740 1120 Luther Drive Hagerstown, Maryland Wilbur J. Myers - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spent) Rest Haven Cemetery Nov.11, 2011 Hagerstown, Maryland 21. Si ature Juneral Service Osborne Aftenerailly Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SECSIS 4-5 DAYS disease or condition resulting in death) Due to (or as a consequence of): VRINARY TRACT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 4-5 0145 PNEUMUNIK Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? WYPERLIP (DEMIK 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown NYPERTENSION HNEMIA 24a. Was an

**Physician** /Medical Examiner

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After t

ne Hospital or Attending Pin 24 hours after death, ne Funeral Director: After the letely filled in by the funeral

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Certification: To

Medical

State

Registrar

**Physician** 

Examiner

**Funeral** 

**Director** 

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28a-f

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12 should be fi th and Mental F 7 Is marked otl

Health a

permit. Pages 1 and Depertment of Health Important: If Item 27 any InJury or other tr.

Maryland 21215-0036

Baltimore,

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Completed

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/Medical

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that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

Examine Physician/Medical ģ Completed page 2

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ∏Yes 2 ∏No 9 Unknown

> 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 2 AND

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death

5 Pending investigation 6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes

26. Place of Death (Check only one)

29a. Certifier (Check only

1 E Natural

2 Accident

4 Homicide

3 Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

-normo

P) 58) G

NOV 8, 2011

HAGERITOWN MO 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DATTA VASAVT 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MOA 0 8



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

340 MILL ST

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State	Department of Health and Mental  Certificate of Death	Hygiene	1 37424			
			Registrar  1. Decedent's Name (First, Middle, Last)		Reg. No. Z U I	3. Time of Death			
	Physicia Medi		HAROLD HENRY MARSH	II Mon NO	th Day Year				
-	Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of De				
Alfr	·		RENAISSANCE GARDENS	SILVER SPRING	PRINCE	GEORGE'S			
	Funeral Director	ı	5. Social Security Number 6. Sex 7. Age (In yrs. last birtho		of Birth 9. B C C 5, 1935 W	sirthplace (State or Foreign Country) ASH. D.C.			
			577-46-0189 76  Usual Residence of Decedent	TO TOUR	5, 1935   W	ASH. D.C.			
	/land f sho d at	ţ	10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits			
	Man 28a-	Director	MD. PRINCE GEORGE'S	SILVER SPRING		1 ☐ Yes 2 😾 No			
	th the 3a or the r	] E	10e. Street and Number	10f. Zip Code	10g. Citizen of What 0	0g. Citizen of What Country?			
	ath wi	Funeral	3154 GRACEFIELD RD. #104  11. Marital Status 12. Was Decedent Ever in U.S.	20904		U.S.A.			
ယ္	or ite	by F	1 Never Married 2 W Married 11 Vos 2 No	<ol> <li>Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> </ol>	or No- c.) 14. Race - Am Black, Wh				
03	ırs aft ıral", I Exal	edi		1 ☐ Yes 2 ▼ No Specify:	Specify: WH	ITE			
15-(	2 hou <b>"nat</b> i edica	plet	15. Decedent's Education 16a. C (Specify only highest grade completed) (6	Decedent's Usual Occupation Give kind of work done during most of working	16b. Kind of Busines				
12	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	ife. DO NOT use retired)	11000				
<b>d</b> 2	led w I Hygi other ent, i	a	17. Father's Name (First, Middle, Last)	CIVIL ENGINEER  18. Mother's Name (First, M	WSSC				
Maryland 21215-0036	d be finda denta	မ	JAMES M. MARSH	ADDIE	RATCLIFF				
lan	should and Me is mar raumati			Mailing Address (Street and Number or Rural Route N		ip Code)			
2	ealth			54 GRACEFIELD RD. #104,	SILVER SPRIN	G, MD. 20904			
Jore	ge 1 and the strategy of the s		1 ☐ Burial 2X Cremation 3 ☐ Removal from State   cemetery,	Disposition (Name of Date crematory or other place)	20c. Location - City of	r Town, State			
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specify) CHAMBE	RS CREMATORY NOV.5,20		E, MD.			
Ba	permit. Departr Imports any inji		21. Signature of Funeral Service Liegnsee  M00091	CREMATORIUM VERDALE,MD.	P.A. 20737				
		ory arrest,	Approximate						
·~.	Physician		Immediate Cause (Final disease or condition VENTRICULAR ARR	RHYTHMIA		Interval Between Onset and Death			
1	Medical Examiner		resulting in death)  Due to (or as a consequence of):						
	-	Jer	Sequentially list conditions, if any, leading to immediate  b. ATHEROSCLEROTIC  Due to (or as a consequence of):	CARDIOVASCULAR DISEASE		YEARS			
	par J	Examiner	cause. Enter Underlying Cause (Disease or iinjury						
	an an rial	I Ex	that initiated events c.  resulting in death) Last  Due to (or as a consequence of):						
09	To Attending Physician: The law requires that the death certificate be executed after death addressed and addressed and addressed and addressed and a defending physician and in by the funeral director, page 2 should be detached for use as the burial the set of the funeral director.	dical	d						
687	aath certifica attending p	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			<u> </u>			
Box 68760	atth c atten I for u	iciar	23b. Was decedent pregnant in the past 12 months?   1   Yes 2   No   4   Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of de Month	Day Year			
<u>п</u>	the de by the ached	hys	9 Unknown			,			
9	s that gned to se deta	by P	Part II. Other significant conditions contributing to death but not resulting in t		Did tobacco use contribute t	o the cause of death?			
Sp.	equire sen si ould b	ted	ATRIAL FIBRILLATION, CONGESTIVE H	EART DISEASE	1 ☐ Yes 2 ☐ No 3 ☐ F	Probably 4 🕅 Unknown			
Division of Vital Records, P.O.	law re has be e 2 sh	Completed	CEREBROVASCULAR ACCIDENT		autopsy prior to	utopsy findings available completion of cause of			
ž,	sician: The law r certificate has b irector, page 2 sl			1 🗆	performed? death? Yes 2X No 1 ☐ Ye	s 2 No			
/ita	siciar certif irecto	Be	25. Was case referred to medical examiner?  1 Ves 2 No  Hospital:	26. Place of Death (Check only one)					
ot	g Phy er this eral d	e: To	27. Manner of Death 28a. Date of injury 28b. Tim	atient 3 DOA 4 X Nursing Home 5 Description of 28c. Injury at 28d Description	Residence 6 Other (Specifies from 1997)	cify)			
0	ath. ir; Aft	icat	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) inju 2 ☐ AccidentInvestigation	work?  M 1  Yes 2 No	ibe now injury occurred				
NISI	fer de irecto	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		on (Street and Number or Ru	ıral Route Number,			
בֿ ב	ours af				r Town, State)	- III - I			
	or the pospital of Attenti within 24 hours after death.  To the Funeral Director; A completed filled in by the fr	Medical	29a. Certifier  (Check 2 Medical Examiner: On the best of my knowledge, deal only one)  3 Offinying Nurse Practioner: To the best of my knowledge.	Nestigation in my opinion death occurred at the time of	late and place, and due to the	coupe(e) and manner stated			
	Vitt Con Con Con Con Con Con Con Con Con Con		29b. Signature and title of certifier	29c. License number	29d. Date signed (Mont				
	9+1			D24035	NOV. 4, 2	2011			
_			30. Name and address of person who completed cause of death (Item 23a) (Type E.S. MACHADO, M.D. 3110 GRACE	pe, Print) FIELD RD., SILVER SPRING					
	State	~	21 Date filed (Menth Day Vers)		15 FID. 20904				
	Registra	r	NOV 07 2011 June 1. 4	asked.					

11-08429 Michelle Orr

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2011 37425

		1- For State Registrar		C	Certifica	te of	Death			Re	g. No.	20	ı	1 3/42	
Physici		1. Decedent's Name (First, Midd	le,Last)							Date of Deat Month	h Day	Year	$\neg$	3. Time of Death	
ledical Exami	iner	Michele E. Orr							N	lovember	9, 20	11		1630 hrs	
t		4a. Facility Name (if not institution	. •	mber)		41	c. City, Town, or		of Death			County of De			
		13535 Coach Lamp L					Silver Sprir			Montgomery  24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or _					
Funeral		5. Social Security Number	6. Sex	7. Age (In yr	rs. last birth	day)	If Under 1 Year Months Day			Date of Birt	h(MM/D	Fo	reian	Rockville.	
Director		212-78-9600	1 M 2 X F	53	3	Yrs.	I Mortano   Day	70 7100.0		05/10	ntry) MD				
h		Usual Residence of Decedent		Line of									一		
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Mary r 28s	Director	10e. Street and Number					10f. Zip Code			10	og. Citize	en of What C	ount	ry?	
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or dea			1 Yes	2 🗶 N	0	· [ ] ,	· • •				Specify: Caucasian				
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215-0036  be filed within 72 hours after death with the Maryland mal Hygiew other than "natural", or items 23a or 28a-f ahe ent, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12)	College (1-				st of working life			done	100.10	ind or busine	33/111	adady	
15-0036 Hiled within 72 ho Hygiene. d other than "na, the Medical Ex	ple		4		Nu	rge					,	Medici	ne		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	S	17. Father's Name (First, Middle,			.,,			18.Mother	's Name (Fire	st, Middle, M					
21215 uld be file Mental H marked c	Be (	Robert Elliot 1	Emerv					Joan	Madia	an					
조 교육 등 하	P	Mobert Elliot Emery     Joan Madigan       9     19a. Informant's Name/Relationship (Type, Print )     19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State,										ate, 3	Zip Code)		
e, MD 21: and 2 should be Health and Meritem 27 is mare traumatic eve		David Orr, Spor	use		135	535 (	Coach1a	mp La	ne, Si	ilver	Spri	ing, M	D	20906	
nore, MD 2 ages I and 2 shou nt of Health and ht: It: If item 27 is nother traumatic		20a. Method of Disposition  1 Burial 2 X Cremation				Dispositi	on (Name of ce		Da			ocation - City			
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Baltimore, permit. Pages l a Department of He Important: If ite		21. Signature of Funeral Service		01102	Oudon	22. Na	me and Addres	s of Facility	Simp1	e Tri	hute	P T T T T T T T T T T T T T T T T T T T		naryiana	
E E E		21. Signature of Funeral Service Licensee MO1102  22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, Ma											v1	and 20852	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart											Approximate Interval Between Onset and		
Medical. Laminer	1	failure. List only one cause on each line.    Immediate Cause (Final disease											Death		
Adminer		or condition resulting in death)	Due to (or as a			,									
	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):													
	ij	cause. Enter Underlying Cause	C.	consequenc	e or).								-1		
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3760, ficate be g physicial the buris		IF FEMALE: 23b. Was decedent pregnant in the		C. If yes, outcome of pregnancy  Live birth  2 Fetal death  3 Ectopic pregnancy								Date of delivery	•	y Year	
Box 68 death certif he attending d for use as	Si	past 12 months?		ant at time of	2 death 5	=	I death 3 er (Specify)	LCtopic	pregnancy		<u></u> † "	VIOTITI	Da	y Teal	
of Vital Records, P.O. Box 68 ing Physician: The law requires that the death certif After this certificate has been signed by the attending timeral director, page 2 should be detached for use as	Physiciar	1 Yes 2 No 9 🗸 Uni	cnown 9 Unknow	wn	- 1	0010									
		Part il. Other significant condit	ions contributing to	death but no	ot resulting i	n the un	derlying cause of	given in Par	rt I.	23e. Did to	oacco us	se contribute	to th	e cause of death?	
res th	d by	Cutting wound	s of both	wrist	s					1 Yes	2	No 3 P	roba	bly 4 🗹 Unknown	
rds requi	Completed									24a. Was a autops				psy findings available mpletion of cause of	
e law	E		<del>.</del> .							perform	ned?	death	?		
R Th		25. Was case referred to medica					26 Place	a of Death (	Check only	1 Yes 2	No.	1 🗸	Yes	2 No	
lirecte	Be	examiner?	Hospital:	patient 2	FR/Out	patient		Other	Nursing Ho		Residen	ce 6 🗸 Ot	her !	Scene	
n of V ding Phy After th funeral d	٤.	1 Yes 2 No 27. Manner of Death	28a, Date of	of Injury		me of Inju		ry at Work?	? 28d.	Describe h	ow injun	v occurred s	3111	riect	
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risic r Atte er dez recto	ica		28e Place				factory, office b	ouilding, etc	c. 28f.	Location (St	treet and	d Number or	Rura	l Route Number, City	
Division pital or Attentours after death										ate)13 Spri	535 Co	ac	h Lamp Ln.		
Hosp 24 hou Functiely fi		29a Certifier	nysician: To the best			occurre	d at the time, da	ate and place							
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director,	edical	(0)10011 0111)	miner:On the basis of and manner sta	f examination											
F ≥ F 8	₹	29b. Signature and title of certifie		3160.			29c. Licens	se number			29d. Da	ate signed (	Monti	n, Day, Year)	
		my a	100				O.C.	M.E.			Nove	mber 10,	201	1	
	ł	30. Name and address of person	who completed cause	e of death (It	em 23a)										
		-	nt Medical Exam				-	timore, M	/ID 21223	1					
	ate	31. Date filed (Month, Day Year) NOV 16 20	32. Reg	gistrar's Sign	ature	Mad	4								
Regist	rar	MUA TO SO													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 1 1

			For State	State of Ma	arylan	d / Depa	artment of I	Health a	nd M	ental Hyg	iene 20		3742	6
			Registrar  1. Decedent's Name (First, Middle, L	.ast)		Cer	uncate or i	Dealli		2. Date of Deat	eg. No.		3. Time of Death	_
	Physicia			Carolyn S.	Proi	ansku					er 03,20	ear 11	9:15am	
	Medic Examin		4a. Facility Name (if not institution, gi		5		4b. City, Town, o	r Location of	Death	140 0 CMB	4c. County of			
				d Place				Cabin.		_	Montgomery			
	Funeral		· ·	. Sex 7. Age 1 ☐ M 2 🔀 F		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2	4 Hrs. Min.	8. Date of Birth Month, Day, June 2	Year)	3. Birthp Count	lace (State or Foreign	1
	Director		337-48-5199 Usual Residence of Decedent		57	115.				June 22	1,1954		Tllinois	_
	and show	ō	10a. State 10b. County		10c. City	y, Town or Loc	ation 10d. Ins					Od. Inside City Limits		
	Maryl 28a-f otifie	rec	Maryland Monte	gomery				Cabin	Joh	n		1 ☐ Yes 2 🛣 No		
	a or	<u>=</u>	10e. Street and Number				10f. Zip Code			1	0g. Citizen of Wh		*	
	th with ms 23 must	Funeral Director		d Place		Las		2081					S.A	_
	or dea	by Fu	11. Marital Status 1 ☐ Never Married 2 🛣 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🛣		5. 13. V	Vas Decedent of F f Yes, specify Cub	lispanic Origii an, Mexican,	n? (Speci Puerto R	ity Yes or No- ican, etc.)	14. Race - Black,	America White, e		
3	s afte ral", Exan	q pe	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	140	1	☐ Yes 2 🗓 No	Specify:			Specify:	(	Caucasian	
2-C	hour "natu dical	Completed	15. Decedent's (Specify only highest				lent's Usual Occup		of working	7	16b. Kind of Busi	ness Ind	ustry	
7	hin 72 ne. <b>than</b> ie Me	mo:	Elementary/Seconday (0-12)	College (1-4 or 5	+)	life. Do	O NOT use retired)			,		T ( )	2	
N D	ed wit Hygie other ent, th	Be C	17. Father's Name (First, Middle, Las	5+		<u> vocu</u>	nentary i			Eimt Middle N	Inidan Surnamal	Fil	an	_
Maryland 21215-0036	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	To		orris Proja	ихьи		18. Mother's Name (First, Middle, Maiden Surnar Marion Ste					,		
ary	2 should by th and Mer 27 is marke traumatic		19a. Informant's Name/Relationship		rosicy	19b. Mailin	g Address (Street	and Number	or Rural i		NUCCON SCENNESS  Number, City or Town, State, Zip Code)			
	id 2 sl alth a n 27 is er tra		Matthew Glasse	r - Spouse		7205	46th St	reet,	Cher	y Chase	e, Maryle	and	20815	
ore	of Healt of Healt if item 2 or other		20a. Method of Disposition 1    Burial 2 □ Cremation 3	Removal from State	20b. P	lace of Dispo emetery, cren	sition (Name of natory or other pla	ce)	Da	ite	20c. Location - C	ity or To	wn, State	
Ĕ	. Page tment o tant: If jury or		4 Donation 5 Other (Spe	ecify)	We		Cemeter				Norridge			
Baltimore,	permit. Page 1 Department of Important: If it any injury or o		21. Signature of Funeral Service Lic		1621								Home, Inc	
	212 0		Neva M. Zung 23a. Part 1. Enter the disease, or co					•				<u>oru</u> n	Approximate	4
	Physician/		shock, or heart failure. List only Immediate Cause (Final	y one cause on each line					ardido or	oopiiator, arro			Interval Between Onset and Death	
	Medical		disease or condition resulting in death)	a. Breast Due to (or as a			th Metas	tases				-		_
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-	π ≓Λ	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequ	ience of):								
	and trans	xan	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	consequ	ience off:						+		
	physician and the burial-transit	dical E	resulting in douth, East											
20/2	icate j physis the	ledi		<b>a</b>										_
200	ending use a	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			Ectopic pregnan	CV			23d. Date	of delive	ery	
ROX	death he att	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ๋�� No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown			Other (specify) _				Monti	1	Day Year	
л Э	requires that the death certificate been signed by the attending phy should be detached for use as the		Part II. Other significant conditions	contributing to death by	ut not res	ulting in the u	nderiving cause gi	ven in Part I.		23e Did tot	acco use contrib	ute to th	e cause of death?	
ς, Τ	res th signe d be c	d by	•	3		. 9	, 33						ably 4 🕱 Unknow	ก
ğ	been	lete								24a. Was ar	24b. We	re autor	sy findings available	_
or Vital Records,	he law te has age 2	Completed								autops	ned? de:	or to con ath? Yes	npletion of cause of	
<u>e</u>	an: Tl rtificar tor, pi	a)	25. Was case referred to medical examiner?				26. P	lace of Death	(Check o	1 Yes 2	Z K I NO I I L	_ Yes	2 L NO	
7	hysic his ce I direc	To B	1 Yes 2 X No			ER/Outpatien	t 3 🗆 DOA Oth	er: 4 🗌 Nurs	sing Hom	e 5 🗓 Reside	nce 6 Other	(Specify)		
0	ling P	ate:	27. Manner of Death 1   ↑ Natural 5 □ Pending	28a. Date of injur (Month, Day	y ; Year)	28b. Time of injury	28c. Injur wor	k?	- 1	3d. Describe ho	w injury occurred			
SIO	ttend death stor: / / the f	Certificate:	2 Accident Investigat 3 Suicide 6 Could no	t be Risco of Inju	n/ - At ho	me farm etre		Yes 2 🗆 N	-	of Location (St	reet and Number	or Puml	Poute Number	_
DIVISION	al or A safter Direct		4 ☐ Homicide determine	building, etc	. (Specify,	)	set, factory, office			City or Town		Ji Nulai	noute Number,	
	To the Hospital or Attending Physician: The law requires within 24 hours after death.  To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be	Medical		hysician: To the best of r										
	the Ho nin 24 the Fu	Med	only one) 3 Certifying N	miner: On the basis of ex urse Practioner: To the b										ea.
	5 \$ 5 \$O		29b. Signature and title of certifier				29c. Licens		1.40		9d. Date signed (			
	)		- lever	′ 0		20.15		D37	142		November	. 03,	, 2011	_
			30. Name and address of person wh					Rachui	880	Manie	nd 20850	ł		
	Stat	te	Geoffrey Coleman 31. Date filed (Month, Day, Year) NOV 0420	37. Registra	r's Signat	re Z	A.A.	TO CICUIO	uc,	murgeu	1.U 20030			_
	Registra		NOV 0 4 20	177 acua	1 1	. 4	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 3, Dorothy Lorrine Pickeral 6:15 ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Renaissance Gardens at Riderwood Village Silver Spring P.G. 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, 1 M 2 D Months Hours 91 **Director** 579-18-1225 June D.C. Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Tes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a o traumatic event, the Medical Examiner must be Funeral 3118 Gracefield Road, CC-517 20904 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc.
White 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. 3XXWidowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Administrative Assistant Own Business Be 17. Father's Name (First, Middle, Last) th and Mental h 18. Mother's Name (First, Middle, Maiden Surname) ည James P. McVerry Elsie Deuterman f and 2 should by Health and Metem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Edward Pickeral/Son 41170 Paw Paw Hollow Lane, Leonardtown, MD 20650 permit, Page 1 and.
Department of Healt
Important; If item 2
any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Veterans Cemetery |Cheltenham, MD 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 th ble C M 98 Part 1. 5 ter t v disease, or complicity in s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death hysician/ disease or condition Pneumonia mos. Medical resulting in death) Due to (or as a consequence of): Éxaminer Lung Mass 2 mos. Sequentially list conditions, rany, leading to infinediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria ca Box 68760 Physician/Medi yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 🛣 No Pregnant at time of death 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Aortic Stenosis Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 certificate 1 Tes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director After this certifical application of the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 🖾 Nursing Home 5 🗌 Residence 6 🗆 Other (Specify) 2**X** No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 XNatural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)
CRNP 3160 Gracefield Road, Silver Spring, MD 20904 30. Name and address of Eileen Gemmell, 31. Date filed (Month, Day, Year) NOV 04 2011

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Joi 1 7:20 (AM bena Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 507 arrol High Acre Westminster mod 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 M 2 F Months Hours 86 82-20-Director 1527 Usual Residence of Decedent show 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No PA York Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5233 Grandview Road 17331 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne
any injury or other traumatic event, the Medie (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Poloskey Michaelina Hammerski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol J. Brown - Daughter 29866 Therese Circle, Mechanicsville, MD 20659 20a. Method of Disposition
1 🔀 Burial 2 🗆 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Mount Olivet Cemetery 11/4/2011 Hanover, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Kenworthy Funeral Home, Inc. 269 Frederick Street, Hanover, PA 17331 CC0354 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ disease or condition 250 Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). sician and burial-transit Cause (Disease or imjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? page 2 should be detached for Pregnant at time of death Month Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗌 No 2 1 within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, it To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? 1 Tes Other: 2 P.No 4 Nursing Home 5 Residence 6 Other (Specify) ASS (LL) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 🗌 No ☐ Accident ☐ Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur title of certifier 29d. Date signed (Month, Day, Year) WIL 17 2 00000 763 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ernesto M. Mendoza, M.D. was 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

NOV 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 37429 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ <sup>Day</sup> 3 2011 NOVEMBER LEWIS PAGE ROBERT 2:45A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4916 LASALLE ROAD HYATTSVILLE PRINCE GEORGE'S Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 XM 2 | F Months Hours Min 578-16-4319 1921 WASHINGTON, DC 90 **Director** Usual Residence of Decedent shov 10a. State 10b. County within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 No MD PRINCE GEORGE'S HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıms 23a or r must be r Funeral 4916 LASALLE ROAD USA 20782 items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 BLACK If Yes, Give Year or Dates 1 Tes 2 No Specify: Specify. "natural", 3 X Widowed 4 Divorced Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the 8th X-RAY TECHNICIAN PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental H 27 is marked of r traumatic ever ပ 1 and 2 should be of Health and Menta ROBERT W. PAGE BESSIE SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOLITA P. CHICHESTER/DGT 1000 BRIGHTSEAT ROAD #108 LANDOVER, MARYLAND 20785 t: If item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 11/1072011 ᇴ 1 X Burial 2 Cremation 3 Removal from State Department o Important: If any injury or LITTLE ZION BAPT. CHUR. OAK GROVE, VIRGINIA 4 Donation 5 Other (Specify) J. B. JENKINS FUNERAL HOME, INC. Funeral Service Licenses 22. Name and Address of Facility Signature of Resul 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. In er ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final ATHEROSCIEROSTS CARDTOVASCIII.AR DISEASE Approximate Interval Between Onset and Death ATHEROSCLEROSIS CARDIOVASCULAR DISEASE Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner PULMONARY EMBOLISM Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed END STAGE RENAL DISEASE and the burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 as attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the a Id be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? certificate Yes 2 XN 2X No 25. Was case referred to medica completed filled in by the funeral director, Be 26. Place of Death (Check only one) 1 Tes 2 X No Other: ျင 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After t Certificate: 28d. Describe how injury occurred 1 XNatural 5 Pending 1 🗌 Yes 2 🗌 No 24 hours after death Funeral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check

within 2

State Registrar  Date filed (Month, Da NOV 0 8 2011

CHRISTIAN LEFEVRE M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2112

3

29b. Signature and title of certifie

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D10731

F. STREET N.W. #603 WASHINGTON, DC 20037

NOVEMBER 4 2011

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ A M MARILYN MARGARET QUINN 3:57 NOVEMBER 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours Country 128-26-3915 Director 1 M 2 X F 77 Yrs 04/24/1934 NEW YORK Usual Residence of Dec 28a-f shov 10a. State 10c. City, Town or Location the Maryland 10d. Inside City Limits Director notified MD QUEEN ANNE'S STEVENSVILLE 1 Yes 2 X No 10e. Street and Numbe o 10f. Zip Code 10g. Citizen of What Country? be Funeral 23a must | 957 CLOVERFIELDS DRIVE 21666 UNITED STATES Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Force or. þ Black, White, etc. 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give "natural", Completed Specify: 3 Widowed 4 Divorced WHITE Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. the 12 SWITCHBOARD OPERATOR MANAGER HEALTH CARE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) marked မ Ith and Ment 27 is marke traumatic JOHN J. SEERY MARY ELIZABETH DOLAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 JOSEPH QUINN / HUSBAND 957 CLOVERFIELDS DRIVE, STEVENSVILLE, MD 21666 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ō Department of Important: If any injury or 11/08/2011 STEVENSVILLE, MD 21. Signature of Funeral Service Licens 2. Name and Address of Facility
ELLOWS, HELFENBE
06 SHAMROCK ROAD HOME, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death NOUMONI Ph\_sician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury the attending physician and thed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy
5 Other (specify) be detached for in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 9 Unknown signed by significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2/ No 1 Yes 3 Probably 4 Unknown page 2 should need 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy perform death? Yes 2 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital မ 1 Yes Other: ER/Outpatient 3 DOA Inpatient 2 🗆 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) Natural 5 Pending death. after death Director; A Accident 1 Yes 2 No Investigation completely filled in by the 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 2 To the F 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

State

29b. Signature and title of certifier

Monica Soun

30. Name and address of person who completed cau

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Registrar

death (Item 23a) (Type, Print)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3:25 am Hilda Quesada November 06. 2011 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months 584-40-0102 **Director** 1 □ M 2 🎗 F Yrs. 81 Puerto Rico June 30,1930 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🗓 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 8510 16th Street, #410 20910 U.S.A. items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner r 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 1 Yes 2 □ No Specify: Puerto Rican Maryland 21215-0036 If Yes, Give Year or Dates Specify: Completed 3 X Widowed 4 Divorced White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 1 and 2 should be of Health and Ments item 27 is marked other traumatic even Geronimo Suarez Herminia Fernandez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tronce, Luis Quesada - Son 8510 16th St., #410, Silver Spring, MD 20910 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State Porta Coeli Cemetery 4 Donation 5 Other (Specify 11/11/2011 Bayamon, Puerto Rico Sign cure f Fune ai Service 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 4007 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) ue to (or a Examiner 0 Section tally list or called if any, leading to immediate cause. Enter Underlying ath certifica...
re as the burial-transit Examine Due to (gr as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown should Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? After this certificate 1 ☐ Yes 2 ☐ No Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: Certificate: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5  $\square$  Pending within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check ertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to 29b. Signature and title ip who completed death (Item 23a) (Type

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Barbara Marie Campbell Ruffin Physician/ Jovember 1 2011 3:16 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Regional Hospita Laurel Laurel Social Security Numbe If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 M 2 K F Hours Min. 577-56-2795 **69** Yrs Washington DC Director May 11. 1942 Usual Residence of Decedent 28a-f show 10a State 10b. County at 10c. City, Town or Location 10d, Inside City Limits Director ems 23a or 28a-f sh r must be notified a MD Prince Georges Upper Marlboro 1X Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20774 Funeral 206 Castleton Drive United States items death v 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. "natural", or by 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: African 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates A merican Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 f. Department of Health and Mental Hygiene. Important: If fleen 27 is marked other than "na any injury or other traumatic event the conce. 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 2yrs Elementary/Seconday (0-12) Entrepreneur Floral Designer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ John Campbell Alma Glover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
206 Castleton Drive, Upper Marlboro, MD 20774 Joe L. Ruffin, Sr. / husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other placel Fort Lincoln Cem. 11/8/2011 Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licenses 7400 Georgia Avenue, NW, Washington DC 20012 0386 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Retween Immediate Cause (Final Onset and Death Metastatic Physician/ olon disease or condition resulting in death) months Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) ling physician and e as the burial and requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ascites, Respiratory Failure, Anemia, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Thrombocytopenia, Diabetes Mellitus II 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law has autopsy page , performed? Yes 2 No Yes rector, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 Yes 2 No မ 1 Nopatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred vithin 24 hours after death. Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be upleted filled in by the 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2 D 28998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pritam S. Saini, MD 9101 Cherry Lane, Suite 211 Laurel, MD 31. Date filed (Month, Day, Year)

State

Registrar

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 29a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	11. Marital Status 1 ☐ Never Mari	ried 2🛣 Marrie		?		n, Puerto F	cify Yes or No- Rican, etc.)	-	Black							
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Physician/. Medical	9	disease or condition resulting in death)	on	a. Adult I	Respi	ratory	Distress	Sync	drome				$\dashv$	Onset and Beath			
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nding F ath. r: After	icate	1 ☒ Natural 2 ☐ Accident	5 Pending Investiga	(Month, Da		injury	work			ou. Describe i	now mju	ary occurred	1				
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the by	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could no determin	28e. Place of In	jury - At ho tc. (Specify		eet, factory, office		2	28f. Location (3 City or Tov			r or Rural	Route Number,			
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Vithir th		29b. Signature and		0.11		7.	29c. License	number			29d. D	ate signed	(Month, L	Day, Year)			
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		30. Name and addre	ess of person where Bakhshi	ho completed cause of L., MD 9	death (Item 406 0	23a) (Type, 1 1d Geo	erint) Orgetown l	Road,	Beth	nesda,	MD	20814					
Stat Registra		31. Date filed (Mont	th, Day, Year)		rar's Signat		4.1										

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Stephanie R. Richards 2011 November 2:20 p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Towson Baltimore Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Hours (Month, Day, Year) 086-18-1769 **Director** 97 1 🗆 M 2 🗶 F June 28, 1914 New York Usual Residence of Decedent 28a-f show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Hampstead Maryland Carroll Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4019 Evergreen Drive 21074 USA Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes If Yes, Give and Mental Hygiene. is marked other than "natural", 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: white Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing <u> Machine Operator</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) pe Stanley Liskiewicz Florence Majewski and 2 should b f Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Rafferty, daughter 2707 Debbie Court, Finksburg, MD 21048 permit. Page 1 and 2 Department of Heath Important: If item 27 any injury or other tr. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) All Faiths Crematory 11/03/2011 Manchester, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** Onset and Death disease or condition resulting in death) DROBROVASCULAR ACCIDENT Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): ng physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician be detached for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregna 5 ☐ Other (specify) Pregnant at time of death Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ATRIAL FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed3 Yes 2 No 1 Tes 25. Was case referred to medical examiner?

1 Yes 2 Ho Be 26. Place of Death (Check only one) မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 - Natural 5 Pending injury thin 24 hours after death.

the Funeral Director: After the fulled in by the full th Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

complete only one 29b. Signature and title of certifier 2 WJL 3 ress of person wha completed cause of death (Item 23a) (Type, Print)

State

Registrar

Day, Year)

NOV 0

32. R

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Stephen Howard Ruby 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Allegany Western MD Regional Medical Center Cumberland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 X M 2 🗆 F Hours 01/19/1949 Country) Maryland 62 Director 215-56-9148 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits notified at Director MD Allegany Cumberland 1 X Yes 2 No 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Examiner must be Funeral items 23a 235 Paca Street, Apt 809 21502 USA death \ 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò þ 1 Never Married 2 Married ☐ Yes 2 ☐XNo Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", Specify: 3 Widowed 4 Divorced Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Janitor Public Schools Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If Item 27 is marked oth any joiry or other traumatic event once, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ၉ Veryl Ruby Helen Louise Willison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victor DeMarino / Uncle 13201 Woodridge Lane, LaVale, MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State emetery, crematory or other place) Hillcrest Mem. Park 11/12/2011 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Sent 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Physician Merkouse disease or condition Medical resulting in death) oleedu **Examiner** Tracell Sequentially list conditions, Examine Due to (or as a consequence of). if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and -transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burialphysician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Pregnant at time of death signed by the a Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform death? After this certificate Yes Yes director, 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 2 🗌 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) hours after death.

neral Director: After this illed in by the funeral di 27. Monner of Death 28a. Date of injury (Month, Day) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 178:5 1 Natural
2 Accident 5 Pending work?
1 Yes 128/11 Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) face of Injury - At home, farm, street, factory, office building, etc. (Specify) flom 1030 LURSING CHRISTIE RD within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 3 of person who combleted cause of death (Item 23a) (Type, Print)
Arrisueno, M.D., 12502 Willowbrook Rd, Ste 670, Cumberland, MD 21502 Arrisueno, M.D.,

State

31. Date file**d** (Month,

Day, Ye 10

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State		State of M	aryland / [		artment of H tificate of L		nd M	lental Hy	giene	201	1 3	7437	
		Registrar  1. Decedent's Name	e (First, Middle, Last)			Cer	lilicate of L	Jeath 		2. Date of De	Reg. No.	201		of Death	
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and show	ō	Usual Residence of 10a. State	10b. County		10c. City, Town									City Limits	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na Cheryl F	ame/Relationship <i>(Typ</i> Riley		ughter 196	. Mailin	g Address (Street a	and Number on Rd. A	r Rural pt.		er, City or To		Zip Code) MD 2	1740	
Page 1 and ment of Heam ant: If item ury or othe			cremation 3 🗆 F	Removal from State	cemeter	y, crem	sition (Name of natory or other place	e)	D	ate	1		or Town, State		
permit. Pa Departmer Important any injury once,			5/ Other (Specify) peral Service Licens		St. Ma	<del>i</del> –	Cemetery  Name and Address Scarp	s of Eacility	ol U	11/18/20	L Ci	ımbe	rland	MD	
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Physician/		Immediate Cause (	pe disease, or compli rt failure. List only one Final	cations that caused cause on each lin	the death. Do n	ot ente		g, such as car		4	rest,		Approxim Interval E Onset an	Between	
Medical Examiner		disease or condition resulting in death)	•	Due to (or as	a consequence of	of):	11 -	W////					500	JEN	
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	in the past 12 r 1  Yes 2 9  Unknown		4 Pregnant a	t time of death	5 🗆	Ectopic pregnand Other (specify)	:y 				Month	Day	Year	
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the Hos nin 24 h the Fun npleted	Medical	(Check 2	Certifying Physic Medical Examine Certifying Nurse	er: On the best of Practioner: To the	xamination and/or	r investi	gation, in my opinic	n death occur	red at t	he time date a	and place an	d due to th	ne cause(s) and r	manner stated.	
Nith Vith Con		29b. Signature and t	1	12			29c. License	number	4				nth, Day, Year)		
401			ess of person who con					100			,,	, -	2-11.		
Stat	e	Shiv Kha	anna, M.D.		ar's Signature			Vale, N	<u>M</u>	21502	_				
Registra	ar	UN	V 1 4 2011	Senia	A. A.	an	2								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 9 Physician/ Month Maxine Rice November 2011 2313 P M Medical 4c. County of Death Allegany 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Allegany Health Nursing & Rehab Ctr Cumberland Social Security Number | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Country) 92 **Director** 217-10-4581 09/15/1919 Marvland Usual Residence of Decedent or 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Directo MD Allegany Cumberland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Page 1 and 2 should be filed within 72 hours after death with t ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a Funeral 21502 USA 515 Linden Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. \$ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: 3 X Widowed 4 Divorced Completed Year or Dates White Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Viola Mae Spidel ၉ Rowan Christopher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 53, Corriganville, MD 21524 William G. Rice, Jr. permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other ti 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State MD Vet Cem @ Rocky Gap 11/14/2011 4 Donation 5 Other (Specify) Flintstone, MD eture of Funeral Service Licenses 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 23a. Part 1 Enter the disease) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate val Between Onse and Death Immediate Cause (Final Physician/ vo ha disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) -transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last burial attending physician for use as the buria Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Pregnant at time of death Year Day 2 🗌 No ed by the a 1 Yes 2 L 9 Unknown 9 | Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nas page performed? Yes 24 N 2 🗌 No 1 Tyes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner' Hospital Other: 1 Tyes မ this 1 Inpatient 2 ER/Outpatient 3 I 4 PNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completed filled in by the fun 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 2011 00033280 2/1 NOV 10

State Registrar

NLL

Box 68760

P.O. |

Division of Vital

625 Kent Avenue, Cumberland, MD

21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gupta

Sunil

31. Date filed (Mo

Κ.

M.D.,

Box 68760 P.O. Records, Division of Vital

Registrar

8+

29a. Certifier

(Check

only one) 29b. Signature a

30. Name and address of person who completed

2011

Coleman, M.D.

NOV 09

31. Date filed (Month, Day, Year)

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ause of death (Item 23a) (Type, Print)

Piccard

82. Registrar's Signature

1355

🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D37142

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Suite 100 Rockville, MD

29d. Date signed (Month, Day, Year)

November 07, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 12:39 am RIOS-Velcz 2011 armen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat 4c. County of Death **Examiner** Hookins Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 581-62-7332 71 3472041940 Puerto Rico 1 □ M 2 🏞 F **Director** 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 0a. State death with the Maryland Director DE Sussex Seaford iral", or items 23a or 28a-f s Examiner must be notified 1 X Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 22330 Bridgeville Road 19973 Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☑ Yes 2 ☐ No Specify: 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No White, etc. White þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates "natural" 3 Widowed 4 Divorced Completed the Medical Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) HOMEMAKET 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) Reyes Velez 17. Father's Name (First, Middle, Last)
Juan Rios 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Evergreen Circle Tobyhanna, PA. 18466 Ismael Rios/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Municipal Cemetery 11/10/20 1 Anasco, Puerto Rico 20a. Method of Disposition 1 X Burial 2 Cremation 3 X Bemoval from State 4 Donation 5 Other (Special PHTLIP OF TWALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Provincian. rhosi disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a nonsequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial registration Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death signed by the ail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an cate has page 2 s autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) Hospital: \_2 🗹 No ဂ 1 🗖 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA Natural
Accident
Suicide 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred iniury 5 Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Kroslingseram re5-000 November 4, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. Wolfe St Battimore Maryland 21287 Krishnas warny Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6:38 am Jennifer Hope Reiches November 04. 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Montgomery Bethesda Suburban Hospital If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Min Month, Day, Year 970 Hours 270-60-1185 Ohio Director 41 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Bethesda 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? the Medical Examiner must be Funeral 23a 20814 U.S.A. 4998 Battery Lane 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black White etc. 1 Never Married 2 Married 9 ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify "natural", 3 - Widowed 4 - Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. within 7 Elementary/Seconday (0-12) College (1-4 or 5+) Marketing/Advertising Administrator Be 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Linda Greenberg Donald Reiches injury or other traumatic permit. Page 1 and 2 should t Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2802 Abilene Dr., Chevy Chase, MD 20815 Arthur J. Salzberg/Brother-in-Law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Removal from State
4 Donfation 5 Qther (Specify) 11/06/2011 | Cleveland, Ohio Olive Cemetery 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Š 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1. Immediate Cause (Final Onset and Death Physician Hypoxemia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Year Breast Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) and I and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe After this certificate Yes 2 X N 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: ည 1 Yes 2 X No 4 Nursing Home 5 Residence 6 Other (Specify 1 🗓 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director, After iniury 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation □ Accider
 □ Suicide completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

0638 Am Reiches Division of Vital Tennifer

> Registrar DHMH 17 Rev 7/2009

State

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Registrar's Signa

Lawless.

1 反 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0051268

8600 Old Georgetown Road, Bethesda, Maryland 20814

29d. Date signed (Month, Day, Year)

November 04, 2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 23, 201<sup>Year</sup> Lawrence Reeves Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🖾 M 2 🗆 F Months Days Min. 1944 554-62-1688 Jan. Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City. Town or Location Director MD Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10527 Montrose Avenue, #1 20814 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? 1 Yes 2 No unk Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 SpecifyWhite 1 ☐ Yes 2 To No Specify "natural" Completed 3 ☐ Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Consultant Architectural Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Albert L. Reeves Helen E. Johnson 19a. Informant's Name/Relationship (Type, Print) Selma Blanusa/Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19725 7th Street, East, Sonoma, CA 954761 and 2 s of Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. Date 7 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Metropolitan Crematory 4 Donation 5 Other (Specify) Alexandria, VA 22 Name and Address of Each Trancis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Signature of Funeral 23a. Part 1. En er the disease complications that caused the 15-th. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail tre. List only one cause on each line Immediate Cause (Final Interstitial Lung Disease Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events that the death certificate be executed Acute Renal Failure Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month 1 Yes 2 No signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? certificate | Yes 2X No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 🛣 No ပ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural injury work? 1 Yes 2 No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Completed filled in by 4 Homicide determined City or Town, State) within 24 hours a Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

28f. Location (Street and Number or Rural Route Number, 29d. Date signed (Month, Day, Year) 24,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Farzad Malenanian, MD 1500 Forest Glen Road, Silver Spring, MD 20910 32. Registrar's Signature

4:45 ам

9. Birthplace (State or Foreign

10d. Inside City Limits

Onset and Death

Day

Year

1 Yes 2 No

Birting. Country

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

NOV 0 7 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 State of Maryland 11/28/2011 of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 12:30 P Andre N. Shorts Nov 14. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Prince George Hospital Cheverly Prince George's 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Social Security Number 25 Hours (Month, Day, Year) Director 250-56-1677 Usual Residence of Dec 1 🕅 M 2 🗆 F 31 July 6, 1980 Washington DC 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland items 23a or 28a-f sho ler must be notified at Director 1 Yes 2 X No Maryland | Charles Waldorf 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2341 Hope Circle 20601 United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

1 Yes 2 No Examiner 0 þ 1 Never Married 2 X Married filed within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black "natural", Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Groundkeeper Arlington National Cem. traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည James E. Shorts Joan A. Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heatth ar Important: If item 27 is any injury or other trauonce. Donnielle F. Shorts (Wife) 2341 Hope Circle, Waldorf, MD 20601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Resurrection Cemetery Nov 23, 2011 Clinton, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexndria 21. Signature of Funeral Service Licensee Kennett Ferry Road, Clinton, MD 20735 14101549 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dué to for as a consequence on: Examir attending physician and I for use as the burial-transit Due to (or as a consequence of): Physician/Medical al or Attending Physician; The law requires that the death certificate be a after death.
I Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months? Month Day Year the a s been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 1 🗌 Yes No 3 🗆 Probably 4 🗆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy perform 2 🗆 No filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Manner of Death 28d, Describe how injury occurred 57 166 By a CAT Wase was in grass off road Certificate: 28b. Time of \$28c. Injury at Year) 1 Natural 2 Accident 5 Pending 2011 M November 12 1 Yes Investigation 28f. Local n (Street and Number or Rural Route Nu City or Jown, State) 25 05 HAV 6 Could not be 28e. Place of Injury - At home farm, street, factory, office 4 Homicide determined building, etc. (Specify) ree Hospital within 24 hours a Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stayled 29b. Signature a 29d. Date signed (Month, completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Τ. 2011 Peter Stathes November 8:30 рМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carriage Hill of Bethesda Bethesda Montgomery Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 579-05-5169 **Director** 1 🛛 M 2 🗆 F 95 Dec. 3, 1915 D.C. Usual Residence of Decede 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 No MD Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 10304 Detrick Avenue 20895 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces? Black, White, etc ō þ 1 Never Married 2 Married Specify: White If Yes, Give Year or Dates. 1936-44 1 ☐ Yes 2 K No Specify. "natural" Completed 3 X Widowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 4 Real Estate Broker Real Estate Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishered of ပ Thomas Stathes Anna Katrivanos other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeff Stathes/Son 10304 Detrick Avenue, Kensington, MD 20895 If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗔 Removal from State Noyo ō Department Important: Il any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Rockville, MD Parklawn Memorial Park Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph.sici\_n/ Inanition disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Atherosclerotic Coronary Artery Disease quentially list no difficult if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): transit that initiated events resulting in death) Last Due to (or as a consequence of): the burial Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 Yes 2 No ρď Day Year Pregnant at time of death g Unknown g Unknown Completed by Be မ Certificate:

The law requires that the death certificate be executed and physician Division of Vital Records, P.O. Box 68760 ed by the at detached f ate has been signed page 2 should be det Jas certificate l To the Hospital or Attending Physician: VIO the Funeral Director: After thi

with the Maryland

death 1

filed within 72 hours after

Baltimore, Maryland 21215-0036

Part II. Other significant conditions co	intributing to death but not res	sulting in the underly	ying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Aortic Valve Repl	acement, Chro	1 Yes 2 🖾 No 3 🗆 Probably 4 🗆 Unknown		
				24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No
25. Was case referred to medical		90.0	heck only one)	
examiner? 1 Yes 2 No	lospital: 1  Inpatient 2	ER/Outpatient 3	g Horne 5  Residence 6  Other (Specify)	
27. Manner of Death  1   Natural  Accident  Investigation		28b. Time of injury M	28c, Injury at work? 1	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
20a Certifier 1 X Certifying Phys	ician: To the best of my know	dedge death occur	red at the time, date and place	e and due to the cause(s) and manner as stated

29b. Signature and title of certifier romas wan un

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year)

> D50534 Nov. 3, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas Masterson, MD

6858 Old Dominion Drive, #104, McLean, VA 22101

State Registrar

Medical

(Check

31. Date filed (Month, Day, Year, 2. Registrar's Signature NOV 04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State Amend Items 23aPtI,PtII,25,27,28a f per me g926,04/19/2012dhb
Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 30. Physician/ James M. Shulman 1600 M October 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🗶 M 2 🗆 F Months Days Hours Washington. DC Director 579-09-0872 Usual Residence of Decedent r 28a-f show notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗓 No Rockville Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 0 ber ral", or items 23a Examiner must b Funeral U.S.A. 1799 East Jefferson Street, #115 20852 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 V Yes 2 No Army If Yes, Give Year or Dates. WWII þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify "natural", 3 Widowed 4 X Divorced White Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Busines's Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Architect Architecture 4 other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ida Apelbaum Max Shulman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ŝ 112 Sondley Pkwy., Asheville, North Carolina 28805 Clifford Shulman - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once, 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State Garden of Remembrance 11/02/2011 | Clarksburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 40020 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of hear) failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of): Atherosclerotic Cardiovascular Examiner Disease CERTIFICATION ROPROVED BY MEDICAL EXAMINES Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or liniury Hupotension that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 Yes 2 G Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by Hip Fracture 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy performed? Yes 2 🗓 No 1 Yes 2 No Vita∐ 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 1 X Yes 2 2 100 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury **Found**; Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Found: 7:00 p. Natural X Accident 5 Pending 2X No Subject fell. 1 Tes within 24 hours after death To the Funeral Director: △ Investigation 10/28/2011 3 Suicide 4 Homicide 6 Could not be Completed filled in by th. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Bural Route Number, City or Town State) 1799 East Jefferson Street,#115,Rockville,MD determined Home Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b Sonatui 29d. Date signed (Month, Day, Year) env 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 8600 Old Georgetown Road, Bethesda, Maryland 20814 Zenuz, Sima Nourani

DHMH 17 Rev 7/2009

State

Registrar

Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 2011 3 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Year) **Director** 267-50-7904 1 □ M 2 🛮 F 74 Feb. 15,1937 FL Usual Residence of Decedent 28a-f shov 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Anne Arundel Shady Side 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20764 4725 Girton Ave. USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status rmed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married þ 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. 55-57 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Nurse Health Care permit. Page 1 and 2 should be filed wii Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Charles Ashley Jane Cheney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Smith (spouse) 4725 Girton Ave. Shady Side, MD 20764 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 11/1/2011 Glen Burnie, MD Atlantic Crematory 21. Signature of Funeral Sovice Licensee 22. Name and Address of Facility Hardesty Funeral Home P.A. 905 Galesville Rd. Galesville, MD 20765 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final VA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Dause (Disease or injury that initiated events resulting in death) Last Examin Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death , the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ aRYNX Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s performed? within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 2 No 1 Yes ပု 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1-Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License numbe ted cause of death (Item 23a) (Type Print) Name and address of person who TNNAPOLIS MD 21401

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month

32. Re

, istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sullivan Marie Jeannie 11:00 A M November 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Ft. Washington Hospital Ft. Washington Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2XXF 577-84-0945 57 9/20/1954 **Director** Washington, DC Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No Maryland Fort Washington Prince George 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20744 9005 Taylor Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No-If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ð 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) D.C. Police Force Lt. Police Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Enrico P. Quattrociocchi Opal J. Baumgardner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George E. Sullivan/Husband 9005 Taylor Lane, Ft. Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State Resurrection Cemetery 11/10/2011 Clinton, Maryland 4 ☐ Donayon 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signat f Funeral Service Licens da 6160 Oxon Hill Rd. Oxon Hill, MD 20745 Approximate Interval Between neat and beath 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ca Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence on or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ ☐ Live Birth 2 ☐ Fetai deal ☐ Pregnant at time of death in the past 12 nonths?
1 Yes 2 page 2 should be detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes Completed 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 1 Yes 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 🗌 Yes npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurs Praptioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 29c. License number 46 29d. Date sinned (Mo) Day, Year) 2011

A. W

DHMH 17 Rev 7/2009

State

Registrar

11711 Livingston Rd. Ft. Washington, MD

20744

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

Amir Mirza-Alikhani

NOV 0 4 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2011

			For State Registrar	itate of Maryland	d / Depa <i>Cer</i>	artment of F tificate of L	lealth and Death		iene 20	11 37448		
	Physicia	n/	Decedent's Name (First, Middle, Last)  Thelma	June		trawderm	an	2. Date of Deat	h	3. Time of Death		
, day	Medic Examin		4a. Facility Name (if not institution, give stree		~	4b. City, Town, or		th	4c. County of I	Death		
*	<u>/</u>		Western MD Regional			W. I	Cumberl			Allegany		
H	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M	7. Age (In yrs. la. 90	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		9. Birthplace (State or Foreign Country) 1/1921 Maryland			
	nd <b>how</b> at	۱	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Loc	ation				10d. Inside City Limits		
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	with the 23a or 3ust be no	Funeral Director	10e. Street and Number 14408 Valley Road	d		10f. Zip Code 21	502	1	0g. Citizen of Wha	t Country? JSA		
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	þ	1 Never Married 2 Married	Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 X No f Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Pue.			pecify Yes or No- to Rican, etc.)		American Indian, Vhite, etc. White		
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121	d withir dygiene ther th nt, the	a)	7	Sollege (1-4 of 5+)		Homemake			Hon	1e		
lanc	the file fental F rrked or tic ever	To B	17. Father's Name (First, Middle, Last)  Charles Fi	rederick	Senkb	eil		me (First, Middle, M nora (	<sup>Maiden Sumame)</sup> Catherine	e Schmidt		
Maryland 21215-0036	d 2 should alth and N 27 is ma		19a. Informant's Name/Relationship (Type, F Debra J. Anderson					ural Route Number, re, Cumber				
Baltimore, permit. Page 1 and Department of Hee Important: If item any injury or othe once.		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ Rem	oval from State	metery, crem	sition (Name of natory or other place			20c. Location - Cit				
altim	mit. Pag partmen cortant: injury ie.		4 Donation 5 Other (Specify)  21. Sgnitture of Funeral Service Licensee	Sun		emorial F			Cumberla lv Funer	and, MD al Home, P.A.		
Ä	permit Depar Impor any in		Hence & Udars	land, MD								
American Control	Medical Examiner	Examiner	23a. Part 1Enter the disease, or complication shock, or heart failure. List only one call Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any scan give mineral cause. Enter Underlying Cause (Disease or injury	Pie to (or as a corresque	ia Pilir		g, such as cardia	o or respiratory arres	51,	Approximate Interval Batween Onset and Death Feur Gary		
.00	cate be executed physician and s the burial-transit	dical Exa	that initiated events resulting in death) Last									
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s, P.O.	requires that the de been signed by the should be detached	d by Pł	Part II. Other significant conditions contrib	uting to death but not resulting to C	Iting in the u	/1	ven in Bart 1.	**		te to the cause of death?		
Division of Vital Records,	has been ge 2 should	mplete						24a. Was an autops	24b. Were	e autopsy findings available r to completion of cause of		
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n of	nding Fith.	cate:	27. Manner of D  th  Natural 5 □ Pending  Accident Investigation	8a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work M 1 $\square$	≀at ? Yes 2 □ No	28d. Describe hov	w injury occurred			
ivisio	Il or Atter after des Director d in by the	Certificate:	3 Suicide 6 Could not be	8e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (Str City or Town,		Rural Route Number,		
	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate he completed filled in by the funeral director, page:	Medical	(Check 2 Medical Examiner: (	: To the best of my knowle on the basis of examination actioner: To the best of my	and/or invest	igation, in my opinio	on, death occurred	at the time, date and	d place, and due to	the cause(s) and manner stated.		
	To the within the country of the cou		29b. Signature and title of optifier  Humbraum			29c. License			9d. Date signed (M			
	ne		30. Name and address of person who compl Huma Shakil, M.D.				land. M	D 21502				
ľ	Stat	e	31. Date filed (Month, Day, Year)	62. Registrar's Signatu						777		

11-08464 Andrew Spruill Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 3741
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		4a. Facility Name (if not institution, give street and num		Polonmo	r Location of Death	on of Death  4c. County of Death  Harford							
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Funeral Director		5. Social Security Number 6. Sex 7 1 M 2 F	65	Months Da			Foreig						
		Usual Residence of Decedent	Itos Oits Town					10d. Inside City Limits					
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uyland In-f sh	οl	10e. Street and Number		10f. Zip Code	SLICAVIP	10g	. Citizen of What Cour	ntry?					
the Man 28	Dire	1203 RAVEN WOOD COURT			21017		UNITED ST	ATES					
5-0036 ted within 72 hours after death with the Maryland lygiene. other than "natural", or items 23a nr 28a-f show the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 Married Armed For	ces?	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>			14. Race - Ameri White, etc.	ican Indian, Black,					
	Ē	1 X Yes 3 X Widowed 4 Divorced If Yes, Give Year-	²∐ № 1965–1986	1 Yes 2 X N	o specify:		Specify: E	BLACK					
ours af atural	ğ D	15. Decedent's Education (Specify only highest grade	completed) 16a. De	ecedent's Usual Occuparing most of working life			6b. Kind of Business/	Industry					
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Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and h Important: If item 27 is n injury nr other traumatic		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	MILMIT	22. Name and Addre	ss of Facility			NIB, PB					
Dep Derri		LISA SCOTT FUNERAL HOME, P.A.  552 LEWIS STREET, HAVRE DE GRACE,  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart											
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Division of Vital Records, P.O. Box 68760, To the Hopital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bucial - transit	Medical	d.  UNPENDED X AMENDED	4a per me g	g922 12-13-	-11 vt								
cat 68760, eath certificate be exe attending physician for use as the bucial	Med	IF FEMALE: 23c. If yes, o	utcome of pregnancy				23d. Date of deliver						
certifica mding ph	Physician/	23b. Was decedent pregnant in the past 12 months?  1 Live bit 4 Pregna	rth 2 int at time of death 5	Fetal death 3 Other (Specify)	Ectopic pregna	ancy	Month	Day Year					
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e law r e has b ge 2 sh	Completed					autopsy perform	ned? death?	completion of cause of es 2 No					
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Division of Vital Records, ral or Attending Physician: The law requirement all birectors. After this certificate has been sited in by the funeral director, page 2 should be			of Injury 28b. Ti Day,Year)		jury at Work? Yes 2 No	28d. Describe ho	w injury occurred						
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Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best one) 2 Medical Examiner: On the basis o	of my knowledge, deat	th occurred at the time,	date and place, and	I due to the cause at the time, date a	(s) and manner as sta	ted. he cause(s)					
To th withi To th	Medical	one) 2 Medical Examiner: On the basis of and manner states 29b. Signature and title of certifier			nse number		29d. Date signed (Mo						
		Danish Amithan mis		0.0	C.M.E.		November 11, 2	011					
		30. Name and address of person who completed cause			01		202						
		[20 Pe	Medical Examiner	900 W. Baltimo	ore Street, Balt	more, MD 21	223						
S Regis	tate		gistrar's Signature	backer									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37450 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $\frac{M}{1}\frac{1}{1}\frac{1}{1}01/2011$ 12:28P Rita Rose Stevenson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6409 Maiden Lane Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. 174-14-3052 95 0242494916 Pennsylvania **Director** Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must he mriffied at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Bethesda Montgomery 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6409 Maiden Lane 20817 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married White 1 ☐ Yes 2 A No Specify: If Yes, Give Year or Dates Completed 3₺ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stephen Joseph Badaracco Mary Marmo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steve Stevenson / Son 6409 Maiden Lane Bethesda, MD 20817 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State 11/08/2011 Silver Spring, MD 4 Donation 5 Other (Specify) Heaven Cemet 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licenses 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Days Immediate Cause (Final Physician/ Respiration Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Years Cerebrovascular Disease Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury 3 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Decades Hypertension that initiated events Due to (or as a consequence of): resulting in death) Last Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No Yes 2 X N 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 XNO 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury X Natural 5 Pending Accident 1 Yes Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Dertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature ar 29d. Date signed (Month, Day, Year) 10 10/02/2011 MD 25992 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

V.

NOV 07

Daniel 31. Date filed (Month, Day, Year)

Young

MD

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Registrar's Signature

4530 Connecticut Avenue NW #104 Washington, DC 20008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Senkbeil, Jr. Harold Luther November 2011 0016 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Western MD Regional Medical Center Cumberland Social Security Numbe Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours (Month, Day, Year) 03/28/1932 79 Director Maryland 220-26-9810 Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director MD Cumberland 1 Yes 2 XNo Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11809 Bayberry Avenue, SW 21502 USA 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. X Yes 2 Norean þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify 3 Widowed 4 Divorced Specify. Completed White Year or Dates. War 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Self-employed Distributor Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Senkbeil, Sr. Virginía Harold Luther and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21502 f Health item 27 Mary N. Senkbeil / Wife 11809 Bayberry Avenue, SW, Cumberland, MD other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 11/07/2011 Cumberland, MD Hillcrest Mem. Park 21. Signature of Funeral Service 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Coronary Artory <u>Years</u> Medical resulting in death) **Examiner** Years Diabetes Mellitus Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events Years attending physician and for use as the burial-transit Hypertension Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death s been signed by the should be detached q | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an or Attending Physician: The law autopsy performed? Yes 2 X No has page 2 this certificate 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 🛚 No 1 🗌 Yes ည 1 Inpatient 2 X ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: eral Director: After filled in by the funer 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital within 24 hours a To the Funeral I completed filled Hospital Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated The dical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Jurse Plactioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifig 29c. License number 29d. Date signed (Month, Day, Year) November 3, 2011 D47699

Registrar
DHMH 17 Rev 7/2009

8+

address of person who

Day, Yea

2011

Ronald Kinsey,

31. Date filed (Mo

completed cause of

M.D.

12500 Willowbrook Road, Cumberland, MD

21502

death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10/31/2011 11:45 P M MINNIE RUBY TYLER Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death Gaithersburg Montgomery Wilson Healthcare Center Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) MD Country) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Days Hours Months 07/03/1915 96 **Director** 217-34-2487 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 X Yes 2 ☐ No Gaithersburg MD Montgamery 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ral", or items 23a or Examiner must be i Funeral USA 301 Russell Avenue 20877 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo
If Yes, Give
Year or Dates. Black, White, etc. age 1 and 2 should be filed within 72 hours arter unent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Store Owner Merchant 6th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Annie Bell Benjamin Burriss 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17708 Garrett Drive, Gaithersburg, MD 20877 19a. Informant's Name/Relationship (Type, Print) Richard G. Tyler, Sr./son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from S Department or Important: If any injury or 11/07/2011 Rockville MD Parklawn Mem Pk 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home Juneral Service Licen 21. Signatu 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disea shock, or heart failure. Immediate Cause (Final 30 nset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impary that initiated events P death certificate be executed and resulting in death) Last **burial** physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Year the Unknown 9 Unknown nas been signed by the 2 should be detach∈ the Hospital or Attending Physician: The law requires that the to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy within 24 hours after death.

To the Funeral Director: After this certificate he completed filled in by the funeral director, page. death? Yes 25. Was case referred to medical lace of Death (Check only one) Be examiner? Other မ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work 1 Tes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 31. Date filed (Month, Day, Year)

son who completed cause of death (Item 23a) (Type, Print)

14. RUBERT BIRSCHBALH, M.B.

04-115

20/ RUSSELL AUENILE CAITHERSSURG, MB o

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Margaret C. Turner 10/30 532pm 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Regency Park Assisted Living Gambrills Arunde1 If Under 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** If Under 24 Hrs Months Days Hours Min (Month, Day, Year) **Director** 219-16-1840 86 1 □ M 2 🕱 F 3/11/1925 MDUsual Residence of Decedent 28a-f shov 10a. State "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Anne Arundel Millersville 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1757 Belle Court 21108 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XXNo Specify White Specify 3 x Widowed 4 □ Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 <u>Homemaker</u> Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Day Carr, Sr. Alice Donaldson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other tra 1535 Waterbury RD. Millersville, MD 21108 Carol McNemar Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XXurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) St. Stephens Cemetery 11/4/2011 | Crownsville, MD 21. Signature of Funeral Ser 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis Rd. Gambrills, MD 21054 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on any line. 23a Part 1 Enter the disease or Approximate Interval Between Immediate Cause (Final Physician/ ment disease or condition Medical resulting in death) Due for as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): nding physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) for Month Day Year Pregnant at time of death detached ģ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signer should be c þ 1 Yes 2 No. 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed certificate Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Doner (Specify) 2 0 No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5  $\square$  Pending work 24 hours after death. Funeral Director: A 2 🗀 No 1 Tyes ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Registrar

within 2 To the F

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Year)

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29b. Signature and title of certifier

only one)

30. Name and addr 1(cof Date filed (Month, Day,

DHMH 17 Rev 06-2011

who completed cause of geath (Item 23a) (Type, Print)

distrar's Signature

32. R

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year) 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Tolodzieck E. serome AM Medical 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death MINGUSITY OF MARYIAND Medical Center BAITIMOR 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 220-30-5221 Director 75 1**XX**M 2 □ F 1/1/1936 MD Usual Residence of Decedent or 28a-f show notified at 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Odenton 1 ☐ Yes 🏋 No 10e. Street and Number ms 23a or must be r ö 10f. Zip Code 10g. Citizen of What Country? Funeral 1321 Huntover Dr. 21113 USA items ? within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or ite Armed Forces Black, White, etc. ò 1 Never Married 2XX Married TX Yes Baltimore, Maryland 21215-0036 2 No White If Yes, Give Year or Dates. 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced Vietnam Specify the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Engineer State of Maryland should be filed w and Mental Hyg is marked othe traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic to Jerome Tolodziecki, SR. Emma Calvert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1321 Huntover Dr. Odenton, MD 21113 Mary Tolodziecki Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State XX Burial 2  $\square$  Cremation 3  $\square$  Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lady of the Fields 11/5/2011 Millersville, MD Signature of Funeral Service Toensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Infance MYOCACHICAL Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying Dire to (ut as a purisequation of): attending physician and if for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death the Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ None 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 🗌 Yes Other: 2 No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4  $\square$  Homicide determined City or Town, State) within 24 hours a To the Funeral C Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) Scetti ND 871892240

State Registrar MO

21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NOV 03

Baltimore

32. Registrar's Signature

October 31

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 22, 2019 7:46 Рм William Trower Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Bowie Health Care Center Rowie Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Country) Vi<u>rgini</u>a **Director** Yrs 577-44-6689 78 Jan. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director 1X Yes 2 ☐ No Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20716 1500 Health Center Drive United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Never Married 2 Married by 1 ☐ Yes 2 ☒ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify. **Black** "natural", 3 Widowed 4 Divorced Completed Year or Dates injury or other traumatic event, the Medical Decedent's Education. 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Carpenter Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ George Trower Adell Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 20785 Jacqueline Harrod - Niece 725 Carlough Street Landover, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Nov. 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory 2011 Clinton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. 10 tis 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Chronic Obstructive Pulmonary Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events and transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last burial physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 9 Unknown g Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Congestive Heart Failure 1  $\boxtimes$  Yes 2  $\square$  No 3  $\square$  Probably 4  $\square$  Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Pulmonary Hypertension this certificate has page performed? Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 XNo ည 1 A Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work' within 24 hours after death,

To the Funeral Director: A

completed filled in by the fu 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ade November 4, 2011 D45217

CR

Registrar
DHMH 17 Rev 7/2009

State

Suite M18

College Park, Md.

6201 Greenbelt Road

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Adebowale Ajayi, MD

8 2011

31. Date filed (Month, Day,

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per phy.,	11					ndelible In artment of			•		gible.			
Allegany	Co.	1 - State Registrar		,		tificate of			,	Reg. No. 2	111	37456		
Physici	an/	1. Decedent's Name (First, Mid		_					2. Date of De	eath		3. Time of Death		
Medi		James W. Tenn							Nove	ember 07, 20	11	12:10 PM M		
Exami	ner	4a. Facility Name (if not instituti Frostburg Village	e Nursing Care	Center		4b. City, Town,								
Funeral Director		5. Social Security Number 219-14-5192	6. Sex 1 <b>X</b> M 2 □ F	7. Age (In yrs. Ia <b>87</b>	ast birthday) Yrs.	If Under 1 Year Months Days		r 24 Hrs. Min.	8. Date of Bir (Month, Danual Janua	th Ty 17, 1924		9. Birthplace (State or Foreign Country) Maryland		
nd show at	ا ا	Usual Residence of Decedent  10a. State 10b. Coun	nty	10c. City	/, Town or Lo	cation				10d. Inside City Limits				
Maryla 18a-f tified	rect	Maryland	Allegany	egany Frostburg								1 ☐ Yes 2 🔀 No		
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 1	2221 Upper Geo	pper George's Creek Rd.			<u>.</u>			10g. Citizen of What Country? U.S.A.				
death items	Fun	11. Marital Status	Armed For	12. Was Decedent Ever in U.S. Armed Forces?			Hispanic Or	igin? (Speci	ify Yes or No- ican, etc.)	14. Ra		can Indian,		
36 after I", or xamir	d by	1 Never Married 2 Nover	larried 1 XYes	1 Xyes 2 No			o Specify		, , , , ,	Specifi		ite, etc.		
-00 nours atura cal E	Completed		Year or Da	ates. WW	16a Deced	lent's Usual Occu	nation				Business Industry			
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within giene ler th, the	ပ္တို	12	O College (1	-4 01 3+)	Supp	ly Clerk			<u>.</u>	Maryla	ind Nat	tional Guard		
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam	To Be	17. Father's Name (First, Middle George Tennant						ner's Name ( <b>nristian l</b>		, Maiden Surnam	re)			
Mary d 2 should alth and M 127 is me	33	19a. Informant's Name/Relation				g Address (Street	t and Numb		Route Number		State, Zip <b>ryland</b>			
of Hear		20a. Method of Disposition				sition (Name of natory or other pla	ace)	Da	ate	20c. Location	- City or T	own, State		
Baltimore, sermit. Page 1 and Separtment of Hea mportant: If item may injury or other		1 № Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Service	r (Specify)		Frostburg	Memorial F	Park		er 09, 201	Frostbu	rg	Maryland		
Bal permi Depar Impor any ir	2	Micholas	7 2015		3	Durst Fur	neral Ho	me, 57		e., Frostbu	rg, MD	21532		
		23a. Part 1. Enter the disease, shock, or heart failure. Lis	or complications that c st only one cause on ea	caused the death ch line.			0.00					Approximate Interval Between		
Phylici n Medical		Immediate Cause (Final disease or condition resulting in death)	_ a A	enti	Tran	matic	Bi	an	· Inj	my		Onset and Death		
Examiner		resulting in death)	Due to (	or as a consequ	ence of):				.0	/				
	je.	Sequentially list conditions, if any leading to immediate	b. — Due to	or as a consequ	ence of									
rted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	5								21			
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876 tifficat ng ph	Med	IF FEMALE:							- (	1	/			
Division of Vital Records, P.O. Box 68760 to the Hospital or Attending Physician: The law requires that the death certificate be awwithin 24 hours after cleath.  To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burian	Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	nant at time of d	Ideath 3	Ectopic pregnar Other (specify)	ncy				ate of deliventh	very Day Year		
P.O that t	y P	Part II. Other significant condi	_		_	. ,	jiven in Part	1.	23e. Did t	tobacco use contribute to the cause of death?				
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Division tal or Attendi rs after death. al Director: A	l Certificate:		28e. Place	na etc. (Specify)		ASS 157 En			Sf. Location (	Street and Numb vn, State)	F. Rura	Royte Number,		
Dir To the Hospital of within 24 hours at To the Funeral D	Medical	(Check 2 Medica	ing Physician: To the be il Examiner: On the basi ing Nurse Practioner: 1	is of examination	and/or invest	igation, in my opin	ion, death o	ccurred at th	ne time, date	and place, and du	e to the ca	ause(s) and manner stated.		
<b>To th</b> withir <b>To th</b> согпр	2	29b. Signature and title of certif		222.01.119		29c. Licens		prace;		29d. Date signe				
M		13	~ )			0	2/7/	40		11/21	20	1.		
1+		30. Name and address of perso	on who completed cause	e of death (Item	23a) (Type, P	rint)	13	, 7				3		
YIM	6	Jesus TAN	4 BR	POACIU egistrar's Signati	AY	FROS	House	29,1	かひ	2.	153	2		
Sta Registr		31. Date filed WPW, Pay, Sea	2011 Perce	egistrar s Signati	pare	1		,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental hygiene state Amend Items 23aPtI,25,27,28a-f per me,9923,01/2/1/2012 the Begistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2011 Mary Ellen Wandell 11:40 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll Hospice Dove House Westminster Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 X Days Hours 0370371931 Buchannon, WV 80 Director 234-44-4074 Usual Residence of Decedent if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2X No Carroll Westminster 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 21157 USA 803 Fairfield Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Specify: White Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Springfield Hospital Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Beatrice Cutwright Charles Hamilton permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Wandell/daughter 803 Fairfield Ave., Westminster, MD 21157 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakeview Memorial Pärk 11/7/2011 Sykesville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Lntracrania disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to (unau a consequence of) Examine if any, leading to immediate cause. Enter Underlying OWAPPROVED BY MEDICA burial-transit Cause (Disease or linjury that initiated events death certificate be executed Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the burial Physician/Medical CERTIFICA IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 1 ☐ Yes ∠ = 9 ☐ Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Certificate: To Be Completed | To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director, After this certificate has been si completed filled in by the funeral director, page 2 should it. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No ☐ Yes 1 🗌 Yes 25. Was case referred to medical of Vital 26. Place of Death (Check only one) examiner? Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28d. Describe how injury occurred
Subject tripped over feet and
fell backwards 28a. Date of injury (Month, Day, Y 28b. Time of 28c. Injury at 3:58 a M 5 Pending 11/01/2011 Natural Division 1 Yes 2 No 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be Suicide 28f. Location (Street and Number or Bural Route Number, City or Town, State 803 Fairfield Ave. Westminster, MD Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) WJL 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1130 13a (HMCH BIVA WES FM INSTER AD 21157 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOVO Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37458 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NO VEMBER Day Joan Macht Medical 5:05 PM 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE JASHINGTON MEDICAL CENTE BURNIE ANNEARISNDEL 5. Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth 1 □ M 2 🕱 F D*a*ys Hours Min. 290-22-5703 (Month, Day, Year) **Director** Kentucky 1924 Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a, State 10b. County filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Severna Park 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1305 North Road 21146 USA 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces 1 Never Married 2 Married ð ☐ Yes 2 XNo Black, White, etc. Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify: 3 XWidowed 4 Divorced Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Secretary Legal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alonzo Richard Macht Carrie Edith Runyan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trau Molly Winkler/Daughter 35 Sunset Drive Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 

Burial 2 

Cremation 3 

Removal from State cemetery, crematory or other place, Nov. 2011 4 Donation 5 Other (Specify) Metro Crematory Baltimore, MD 21. Signal te of Fureral Service Licens 22. Name and Address of Facility
Barranco & Sons, P.A.
495 Ritchie Hwy. Severna Park Funeral Home Severna Park, MD 21146 23a. Parvi. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of): Interval Between Onset and Death Physician Medical PAYS **Examiner** FIBRILLATION 2 YEARS Sequentially list conditions. If any seeing to miniedle cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami resulting in death) Last Due to (or as a consequence of) To Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 2 No Month Year 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 🔀 No 1 Tes 2 No ours after death.

neral Director: After this certific filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0061832 NOVEMBER 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAIN 301 HOSPITAL DRIVE, GLENBURNIE, MD 21061 31. Date filed (Month, Day, Year) NOV 0 3 2011

DHMH 17 Rev 7/2009

State Registrar

Ö

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Susan Ashleigh	Wo	Itz S 1- For State Registrar	tate of Maryla		artment o		d Mental H		Reg. No. 20	11 3745		
Physici Medical Exam		1. Decedent's Name (First, Midd	dle,Last) Ashleigh	Woltz		<del></del>		2. Date of Dea Month		3. Time of Death 0720 hrs		
of the second		4a. Facility Name (if not institution 99 H Charles Street				4b. City, Town, or Westminste			4c. County of D			
Funeral Director		5. Social Security Number 217-33-6547	6. Sex 7	7. Age (In yrs. la 20	ast birthday) Yrs	If Under 1 Yea Months Days	r If Under 24Hr		rth (MM/DD/YYYY) 9.	Birthplace (State or reign MD		
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Baltimore, MD 2 permit. Pages   and 2 shou Department of Health and N Important: If item 27 is n injury or other traumaric		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place)  South Carroll Crem 11-13-11 Sykesvil  21. Signature of Funeral Service Licensee, 22. Name and Address of Facility Fletcher Funeral										
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50, te be executed sysician and burial - transit	AMENDED 23a,27,28a-f,per me,g922 12-15-11 sm    AMENDED 23a,27,28a-f,per me,g922 12-15-11 sm   IF FEMALE:   23c. If yes, outcome of pregnancy   23d. Date of delivery   23d. D											
Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The law requires that the death certificate hin 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physopletely filled in by the funeral director, page 2 should be detached for use as the broad the page of the broad for the page of the broad for the page of the broad for the page of the broad for the page of the broad for the page of the broad for the page of the broad for the page of the broad for the page of the broad for the page of t	If FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month  Month  Pregnant at time of death 9 Unknown  23d. Date of deliv Month  Pregnant at time of death 9 Unknown  23d. Date of deliv Month									ery Day Year		
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WJZ		29b. Signature and title of certifie				29c, License O.C.M			29d. Date signed (M. November 12, 1			
		30. Name and address of person  Donna M. Vincenti, M.	Assistant Me	dical Exami	iner 900 V	V. Baltimore S	Street, Baltim	nore, MD 212	223			
Sta Registi	_	31. Date filed (Month, Day, Year)	2011 Sere	strar's Signature	par	w		-				
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f Healt item 2 other		20a. Method of Disp	oosition		20b.	Place of Dispo	sition (Name of			Date		Location -			_
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fur	neral Service Lic	ensee //	1	22	Name and Addre	ss of Facility	ZIN	L& NEWI	MAN	FUŅĘŖ	RAL H	IOME, P.A.	
				emplications that cal					_			ID 216	19	Approximate	_
Physician/		shock, or hear Immediate Cause ( disease or conditio	Final	y one cause on each	s line.	1/1/2	ANG LAN	1cer						Interval Between Onset and Death	
Medical Examiner		resulting in death)		a. a.	as a conseq	uence of):	Ü								
6	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying											+		-
executed ian and urial-transit	Examiner	Cause Chief inderlying Cause (Disease or injury I that initiated events resulting in death) Last Due to (or as a consequence of):												_	
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IE EENALE.	- 3	d											_
th cert ttendin or use	ian/I	IF FEMALE: 23b. Was decedent in the past 12 r	months?		rth 2 🗌 Fet	Ectopic pregnancy  Other (core)(h)  23d. Date of delivery  Month Day Ye							*		
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s that the	by P	Part II. Other signif	icant conditions	contributing to dea	th but not res	sulting in the u	ınderlying cause gi	ven in Part I.		23e. Did to				e cause of death?	
equires een siç nould b	eted									1/2				pably 4 ∐ Unknown	1
e law r e has b ige 2 sl	Completed								_	24a. Was auto perfo	psy ormed?	pi de	rior to cor eath?	psy findings available inpletion of cause of	
an: Th tificate tor, pa	Be Co	25. Was case referre	ed to medical				26. P	ace of Death (C	Check	1 Yes	2 1	No 1	☐ Yes	2 🗌 No	_
hysici his cer al direc	으		<b>I</b> No			ER/Outpatier		er: 4 🗌 Nursin		me 5 Resid					
ding P th. After t funer?	cate:	27. Manner of Death  1 Natural 2 Accident	n 5 ☐ Pending Investigat		injury Day, Year)	28b. Time of injury	work	yat ⟨? Yes 2 □ No		28d. Describe l	now inju	iry occurre	d		
· Atten er dea rector; by the	Certificate:	3 Suicide 4 Homicide	6 Could no	t be 28e. Place of	Injury - At he		eet, factory, office		$\rightarrow$	28f. Location (S			or Rural	Route Number,	_
oital or															_
e Hosp 24 ho e Fune bletely t	Medical	29a. Certifier 1 (Check 2 only one) 3	Medical Exa	hysician: To the bes miner: On the basis urse Practitioner: T	of examinatio	n and/or invest	tigation, in my opinio	on, death occurr	red at	the time, date a	and plac	e, and due	to the cau	ise(s) and manner state	ad
To th within To th comp	<	29b. Signature and					29c. Licens	e number			29d. Da	ate signed	(Month, E	Day, Year)	
12.				NO	- # - I. W "		295	0+1			111	1111			_
M		30. Name and address	ess of person wh	o completed cause	or death (Iten しいいる	n 23a) (Type, F , Mとり	rint) 11.1 Plan	W SL	۷٫۱	11 210	DO	20	chy	MO 2141	10
Stat Registra		31. Date filed (Mon	10V Year) 8	2011	istrar's Signa	itures.	Print) Play					7			
152 516						<b>#</b>									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State 11-15-11 Amend#19. Per Informent POCCr Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 29, Physician/ 201<sup>Year</sup> 6:37 P M Issac Nathaniel Washington Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Capitol Heights 607 Sisalbed Court . Sex 1 M 2 □ F 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Hours July 22 Country) DC 88 Director 578-24-0787 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 X Yes 2 No Capitol Heights Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9 er than "natural", or items 23a o Funeral United States 20743 607 Sisalbed Court filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Was Decedent Ever in U.S. Black, White, etc. Armed Forces?
1 ☐ Yes 2 🔀 No δ 1 Never Married 2 Married ☐ Yes African Maryland 21215-0036 American 1 ☐ Yes 2 No Specify If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates 16a, Decedent's Usual Occupation 16b Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. 7 is marked other than "I Elementary/Seconday (0-12) College (1-4 or 5+) Government Social Worker 18. Mother's Name (First, Middle, Maiden Surnar Jones Be 17. Father's Name (First, Middle, Last) မ Charlotte Jackson Isaac M. Washington Department of Health and Ment Important: If item 27 is marke any injury or other traumatic ( 1 and 2 should b of Health and Mer item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20774 8961-C Town Center Circle Largo, Maryland Ivy N. Washington - Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Page 1 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Lincoln 2011 Suitland, Maryland Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 20019 Washington, DC 4001 Benning Road NE leway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition ESPIRATORU Physician resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician d be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 X No 3 Probably 4 Unknown Records, 1 🔲 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performer Yes 2 1 Yes 2 No certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Hospital: ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: After Natural injury 5 Pending 1 Yes 2 No Accident Investigation 24 hours after death Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 ho

To the Fune

completed fi (Check Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29d. Date signed (A onth, Day, Year)

State Registrar AUD NA 31. Date filed (Month, Day, Ye NOV 0 8 20

AUTH WAY

SUITLAND MD

of death (Item 23a) (Type, Print)

completed caus

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Helen Mae Walls November 11, 2011 09:30 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 22 Davidson Street Allegany Frostburg Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 K Months Maryland 92 Vrs August 04, 1919 213-10-9741 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Allegany Frostburg 1 XYes 2 No should be filed within 72 hours after death wurrunan and Mental Hygiene.
7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 Davidson Street Funeral 21532-U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+ Sales Clerk Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Tomlinson Ora Devore other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 st it of Health a If item 27 is Kay Weslow daughter 18637 Cherry Lane Frostburg Maryland 21532-Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 1 Burial 2 Cremation 3 Removal from State ō Department Important: If any injury or Frostburg Memorial Park Maryland November 14, 2011 Frostburg 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
ONE YOUR Immediate Cause (Final Physician/ disease or condition resulting in death) CONGESTIVE HEMRT Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Liner Underlying Cause (Disease or linjury Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph I for use as th IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Year Dav Pregnant at time of death the a Unknown g Unknown signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown RENAL FAILURE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: \_2 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury work 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation M within 24 hours after death

To the Funeral Director: A

completed filled in by the 1 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital or within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and ti 29d. Date signed (Month, Day, Year) DOU 33417 (MARKEMOD) NOVEMBER 14, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

James Moen ate filed (Month, Day, Year)

NOV 14

1068 National Hwy.

32. Registrar's Signature

LaVale MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 3, 2011 Kenneth Woodrow Young 5:57 Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Carroll Westminster Carroll Hospice Dove House 7. Age (In yrs. last birthday) **56** Yrs If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, ) Aug 30, 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Hours <sup>Year</sup> 1955 Director 217-62-9117 Baltimore, MD Usual Residence of Decedent 1∩a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a MD Carroll Westminster 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 4595 Wilders Run Lane 21158 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. 0 þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Saltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2X No Specify: "natural", Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) State of MD Dept. of of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Psychiatric Social Worker Human Resources Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Leonard W. Young Ethel M. Ervine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4595 Wilders Run Lane, Westminster, MD 21158 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or other trau Kathy H. Young - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)

Carroll Cremations 1  $\square$  Burial 2X Cremation 3  $\square$  Removal from State 11/9/2011 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facilit Pritts Funeral Home & Chapel, PA Mul Washington Rd. . Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ YYKO disease or condition eciy 5 Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence or) signed by the attending physician and be detached for use as the bunal-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the burn P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Fetal death Pregnant at time of death in the past 12 months? Month 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records. 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 2 10 ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Natural Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) WIL 12 lestminster 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore BIVA 30 YAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37464 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 01 Physician/ 11:06 ам Edna Irene Zirwes November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hillhaven Assisted Living Facilities Adelphi . Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) July 14, 1904 9. Birthplace (State or Foreign 6. Sex **Funeral** Days 1 M 2 X F Country Maryland Hours Min. Director 215-48-2174 107 Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Adelphi Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? Funeral 20783 U.S.A. 3210 Powder Mill Road. should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces þ 1 Never Married 2 Married 1 Yes 2 X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify 3 XWidowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Abraham Rife Cora Emma Lizzie Walmer , Page 1 and 2 should tment of Health and N tant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8020 Barron St., Takoma Park, Maryland 20912 Robert A. Platky/Estate Executor 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Specify) Entombment 6 Department of Important: If any injury or Ft. Lincoln Maus. Brentwood, Maryland 11/08/2011 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signature of Funeral Service Licensee MD20904 11800 New Hampshire Ave., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician End Stage Chronic Obstructive Pulmonary Disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Vear Pregnant at time of death 5 Other (specify) Yes 2 X No signed by the a g | Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Failure to Thrive 1 🗌 Yes 2 X No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? Hupertension 24a. Was an certificate has autopsy performed 2 🗌 No 1 🗌 Yes Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Assisted Other: 4 Nursing Home 5 Residence 6 X Other (Specify, 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director: After this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be filled in by the 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

9055 Chevrolet Drive. #100. Ellicott City, Maryland 21042

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Njide Udochi, M.D.

NOV 0 4 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month mderson 7:40AM Physician/ November Willie 2011 Medical 4c. County of Death not institution, give street and number **Examiner** Baltimore thres GWYNN 9. Birthplace (State or Foreign If Under 8. Date of Birth **Funeral** Country) (Month, Day, Year) 11-14-1930 Director 1 □ M 2 👿 81 10d. Inside City Limits 28a-f show 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Numbe Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S Black, White, etc. Armed Forces' 2 No 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) uy/Sed ondary (0-12) College (1-4 or 5+) Be homas Place of Disposition (Name of 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Arbutus 4 Dopation 5 Other (Specify) e of Fune Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiovalcular Disease Physician/ Athenoscientic disease or condition Medical Examiner resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed' 2 🗆 No 1 Tes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certificate: injury 1 Natural Accident 5 Pending 2 🗌 No within 24 hours after death

To the Funeral Director: /
completely filled in by the i Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) \_\_ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier nsky aparanio 11/23/11 D6057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltmore MD Rajapakse InsiD N 5213 7835 Smxn 32. Registrar's Signature 31. Date filed State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 3:35 PM Helen Allen 2011 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner NIA Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 XF Days Country), 212-34-7560 74 Yrs. Washington, DC 04, 11, 193 **Director** Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show 1 Yes 2 □ No r 28a-f s notified MD Director xaltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ltems 23a or ner must be n Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?1 ☐ Yes 2 X No If Yes, Give Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Bla 3 Widowed 4 Divorced Year or Dates: 'natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Secondary (0-12) College (1-4 or 5+) Elementary and Mental Hygiene.

Is marked other than Assembl 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be liamson ဂ္ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Madeline lianson 101 rc other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Location - City or Town, State Date ō **= 6** Cremation 3 - Removal from State 1 Burial Department of Important: If any Injury or once. 5 Other (Specify) 4 Donation 21. Şignature of Funeral Service Licens 22. Name and Address of Facility 460 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car this or respirator Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** TWO DAYS SEPSIS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs Lissace or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 

Ectopic pregnancy Live birth 2 Tetal death in the past 12 months? Month Veat Pregnant at time of death 5 Other (specify) signed by the at 2 X No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown een sig Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an pate has le autopsy performe 2DONo 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 XInpatient Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 | Yes 2 X No 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 🗌 Yes 2 🗍 No 2 Accident the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State)

Box 68760, Division of Vital Records, P.O. or Attending Physician: after death. Director: Aft filled in by within 24 hours a

To the Funeral C

completely filled Hospital

29a. Certifier Medical (check only 1 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number RES 001 29d. Date signed (Month, Day, Year) 11,19,2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

YANG

4940 Eastern Avenue, Baltimore, MD, 21224

State Registrar 31. Date filed (Month, Day, Year) 82. Registrar's Signature 8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month VICTOR O'NEIL BLOUNT ovember 30 Medical 4a. Eacility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death LATA PDICAL HARLE IVISTA Social Security Number Sex 1 M 2 D F If Under 24 Hrs. 7. Age (In vrs. last birthday If Under 8. Date of Birth Funeral g. Birthplace (State or Foreign Months Days OCT . 7 MARY LAND 217-80-1885 Yrs 1959 Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 😾 Yes 2 🗌 No MD PRINCE GEORGE'S OXON HILL ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2105 ALICE AVENUE APT# 203 20745 USA 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ NoARMY If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 9 ò 1 Never Married 2 XMarried BLACK 1 ☐ Yes 2X No Specify: Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates. Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of and 2 should be filed within 72 lof Health and Mental Hygiene. If item 27 is marked other than "r rother traumatic event, the Medi Elementary/Seconday (0-12) College (1-4 or 5+) COOK PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ CHESTINE WYCE KELLY M. BLOUNT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2105 ALICE AVENUE APT 203 OXON HILL, MARYLAND 20745 LOUISE BLOUNT/WIFE Department of Health Important: If item 27 any injury or other to once. Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) RESURRECTION CEMETERY 12/6/2011 CLINTON, MARYLAND 21. Signature of Puperal Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. LANDOVER ROAD HYATTSVILLE, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a conseque Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Law Increase Director: After this certificate has been signed by the attending physician and eted filled in by the furneral director, page 2 should be deteched for use as the burial-transit that initiated events resulting in death) Last Due to (or as a con-Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year 1 ☐ Yes ∠ ∟ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: 1 Yes မ 1 Nnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending work? 2 No М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined building, etc. (Specify) within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 2011 ame and address of person who completed cause of death (Item 23a) (Type, Print) Umais 31. Date filed (Month, Day, Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9 PM 18 MIZO Medical JEOMIN November 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death The Johns Hookins Hospita Baltimore vrs. last birthday 8. Date of Birth 2 (Mogh Day, **Funeral** If Under 24 Hrs 9. Birthplace (State or Foreign 1 ■ M 2 □ F Days Country) MD Director 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits timore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. be filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Black "natural" Completed 3 Widowed 4 Divorced Specify: Il Hygiene. other than "natura vent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) ost of working Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) Name (First, Middle, Maider Ith and Mental F 27 is marked of traumatic ever ည Informant's Name/Relationship (Type et and Number or Rural Route Brown Health a Wenue 4 other t Department of Healt Important: If item 2 any injury or other altimore, 20a. Metho d of Disposition 20b Place of Disposition (Name of cemetary, crematory) or other p 1 M Burial 2 Cremation 3 Removal from State oodlawn 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Lremia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? detached for Month Year Day Pregnant at time of death Yes 2 No 9 Unknown Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 YNo 3 ☐ Probably 4 ☐ Unknown 1 Yes page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? hours after death. Ineral Director: After this certificate 1 Yes 2 No Yes Yes To the Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita 2 No မ 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending injury work? 2 Accident 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) November 22, 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kupr lomas 600 N.Walfe St Baltimore Maryland 31. Date filed (Month, Day, Year State 2. Registrar's Sign NOV 28 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 9,16b,17 per inf., 9922,12/08/2011dhb
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Melvin Month Year Brummitt Medical 20 Nov 201 9:20 PMM 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5750 Port Tobacco Road Indian Head Charles Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 Alabama M 2 🗆 F Months Days (Month, Day, 419-62-4446 Hours Min. Year. **Director** Yrs 65 946 Jan Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland riment of Health and Mental Hygiene. It it item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State aţ 10b. County 10c. City, Town or Location Director 10d. Inside City Limits notified MD Charles Indian Head 1 Yes 2 No 10e. Street and Number 10f. Zip Code "natural", or items 23a o edical Examiner must be 10g, Citizen of What Country? Funeral 5750 Port Tobacco Road 20640 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 1662-11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1962 1968 1 Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) ABF Freight College (1-4 or 5+) 7. Father's Name (First, Middle, Last) Truck Driver ABS Freight permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) ည <del>erbert</del> Brummitt Erma Mackey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Blandean Halsey-Brummitt-Wife 5750 Port Tobacco Road, Indian Head, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Brummitt Cemetery Donation 5 Other (Specify) 11-26-2011 Camp Hill, AL 21. Sign neral Service L 22. Name and Address of Facility Vines Funeral Home 500 B Street SW, Lafayette, AL Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1. Approximate Interval Between Immediate Cause (Final Physician. Onset and Death ncel disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death). Let Examine Due to for as a consequence un. the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last ician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day signed by the a d be detached f Physic Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy performe death? certificate Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tyes 2 34 Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deat 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No. Investigation Could not be M 24 hours after deat Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death-(Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Sgnatu

11-08523 Unk Unk

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2011 37470

	1- For State Certif	icate of Death	Reg. N	No.			
Physician/	Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death			
edical Examiner	Sandy Lina Beltran		Month Day November 13				
N. B. C. C. C. C. C. C. C. C. C. C. C. C. C.	4a. Facility Name (if not institution, give street end number)  Rt 3 at Rt 450	4b. City, Town, or Location of D Bowie		4c. County of Death Prince George's			
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last		Min. Dec. 8,	M/DD/YYYY) 9. Birthplace (State or Foreign 1987 CaP中的rnia			
the Maryland or 28s-f show any iffled at once.	Usual Residence of Decedent  10a. State 10b. County 10c. City, To Maryland Prince George's Bowi  10e. Street and Number	wn or Location .e 10f. Zip Code	10g. C	10d. Inside City Limits 1 X Yes 2 No Citizen of What Country?			
ith the M 23a or 2 notified	16501 Governor's Green Road Brid	ge 20716		. S . A .			
by MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 23a-f she traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status  1 X Never Married  2 Married  3 Widowed  4 Divorced If Yes, Give Yeer  12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2 X No	If Yes, specify Cuban, Mexican, Po	uerto Rican, etc.)	White, etc.  Specify: White			
5-0036 ed within 72 hours afti- tygiene. tybered than "natural" the Medical Examine Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	Sa. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use	d of work done 16b	b. Kind of Business/Industry			
5-0036 ted within 72 Hygiene. other than ' the Medical Compley	11	Server	lame (First, Middle, Maid	Restaurant			
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than antife event, the Medicannife event, the Medicannife Page Comple	17. Father's Name (First, Middle, Last) (Unknown)	Sandr	a Beltran				
Should Me and Me arise on To	1,77, ,	19b. Mailing Address (Street and Number 850 E. 52nd St., Lo					
e, MD I and 2 sho Health and item 27 is r traumati		ce of Disposition (Name of cemetery,		c. Location - City or Town, State			
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Depa Depa Injur	Laur Yathur	22 Name and Address of Facility Metropolitan Fur 5517 Vine St., A	lexandria,	VA 22310			
Physician • /Medical	23a. Part I. Enter the disease, or complications that caused the death. Defailure. List only one cause on each line.	o not enter the mode of dying, such as card	iac or respiratory arrest, s	shock, or heart Approximate Interval Between Onset and Death			
xaminer	Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a consequence of):						
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause c.						
ecuted and transit	events resulting in death) Last  Due to (or as a consequence of):  d.						
60, ate be execu hysician and e burial - tra	UNPENDED AMENDED						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Functural Director: After this certificate has been signed by the attending physician and completely filled in by the finneral director, page 2 should be detached for use as the burial - transledical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnant 1 Live birth 4 Pregnant at time of death	2 Fetal death 3 Ectopic pr		23d. Date of delivery Month Day Year			
J. Bo trucked deat by the at ached for Phys	1 Yes 2 No 9 ✓ Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resu	liting in the underlying cause given in Part I	. 23e. Did tobac	co use contribute to the cause of death?			
ires that the signed by the detacle				No 3 Probably 4 Unknown			
Records, The law requires ficate has been sig , page 2 should be			24a Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?			
tal Rection: The certificate ector, page	25. Was case referred to medical	26 Place of Death (Ch		No 1 Yes 2 No			
Sician is certification	examiner? [Hospital: 4 ] Innations 2 ] [5]	7.0		sidence 6 🗸 Other: Scene			
Division of Vital Records, lal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sided in by the funeral director, page 2 should lartification: To Be Completed	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month: Day, Year) FOUND: Day, Year)	3b. Time of Injury 28c. Injury at Work? OUND: 1 Yes 2 No	28d. Describe how	injury occurred			
Division or pital or Attending tours after death, nearl Director: After filled in by the fune Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At hom	029 hrs e, farm, street, factory, office building, etc.	or Town, State	et and Number or Rural Route Number, City			
Division To the Hospital or Attend within 24 hours after death To the Funeral Director completely filled in by the	4 Homicide determined (Specify) Major Road / Highway Rt 3 N at Rt 450, Bowie, MD  29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
To the Ho within 24 To the Pu completel	and manner stated.  29b. Signature and title of certifier	29c License number		od. Date signed (Month, Day, Year)			
	auet	O.C.M.E.	N	lovember 13, 2011			
	30. Name and address of person who completed cause of death (Item 23 Ana Rubio MD. Assistant Medical Examiner 90		, MD 21223				
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 2 8 2011	pare					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 37471 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Veronica Rose Baranoski Nov. 22 2011 6:35 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Heritage Nursing Home Dunda1k Baltimore Co. 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) Months Days Hours Min 217-12-8869 Director 1 M 2x F 89 Dec. 20,1921 Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore City N/A MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21224 United States 802 South Lakewood Avenue items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. or 2 1X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify. Specify "natural", 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Years Secretary Exxon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Pelagia Kolasinski Francis Amos Baranoski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) I and 2 s Health tem 27 i Mr. Joseph Baranoski (Nephew) 1106 Pilgrim Road Churchville, MD item 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Important: If any injury or once. New Cathedral Cemetery 11/28/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. (h 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the diseas Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final FUS «Physician/ disease or condition resulting in death) Medical as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury TRACT INFECTION Exami tran and that initiated events resulting in death) Last physician a the burial-BRILLATION Physician/Medical certificate be Box 68760 as the attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? ξ Month Day Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown P.O. signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, 1 Yes 2 No 3 Probably 4 Donknown Completed Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy this certificate has 1 🗌 Yes 1 Yes 2 No Hospital or Attending Physician: Division of Vital 25. Was case referred to medica 26. Place of Deat heck only one) Be examiner's Hospital Other 1  $\square$  Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) of Death 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide 24 hours after death. Funeral Director: A Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatu

DHMH 17 Rev 06-2011

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death 5;25 AM Ivan Eugene Bowser, Jr. 2011 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Lutherville Baltimore College Manor 7. Age (In yrs. last birthday) 83 Yrs. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) August 31 1928 Pennsylvania 9. Birthplace (State or Foreign Hours 218-26-8828 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Baltimore Timonium 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 203 Coldbrook Road 21093 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 TYes 2 □ No If Yes, Give 1946-1948 Year or Dates 1946-1948 1 ☐ Never Married 2 X Married Specify: White 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Music Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Eugene Bowser, Sr. Ida Decker Ivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Coldbrook Road Timonium, Maryland 21093 Nancy Bowser / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 11/28/11 Timonium, Maryland DulaneyValleyMem.Gdns. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of FacilityRuck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Pert1. Enter the disease, or coralications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset end Death Dementia Immediate Cause (Final disease or condition resulting in death) Advanced Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Due to (or es e consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown 24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 Yes 2 No 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1☐Yes 2☐No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and manner es steted 2 Medical Examiner: On the besis of exeminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner steted. 29b. Signature end title of certif 29c. License number 29d. Date signed (Month, Day, Yeer)

**Physician** 

/Medical

Examiner

Director

Funeral

2

Completed

**Funeral** 

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

00

Item 27 is other tra

**Physician** 

/Medical

Examiner

the bunel-transit

i or Attending Physician: The law requires thet the death certificete be executed efter death.

of Vital Records, P.O. Box 68760.

**Division** 

Examine

by Physician/Medical

Completed

Be

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Certification:

Medical

funeral

efter death.

24 hours

To the within 2

injury or Department of important: If any injury or once.

Pages 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Heelth and Mental Hygiene.

3altimore, Maryland 21215-0020

31. Dete filed (Month, Day, Year) State Registrar

32. Registrar's Signature

NOV 2 8 2011

ho completed cause of de

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 19 Physician/ 11 1920 PM KENNETH BANLS 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CENTER MEDICAL DRE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birtl 9. Birthplace (State or Foreign Month, Da Funeral Months Hours Min. Country) -32 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Fes 2 No 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral KSA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 No Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnan ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) a 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility radley 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ MESENTERIC WFARCTION disease or condition resulting in death) Medical Dusto (or as a consequence of): **É**xaminer Sequentially list conditions, Examine if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of): ending physician and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Month Year Pregnant at time of death signed by the a 4 ☐ Pregnant of Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 Yes 2 No 3 Probably 4 Yunknown certificate has been s irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒️No 24a. Was an autopsy performed? Yes 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) 2 🔀 No 1 Mnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: A: completed filled in by the fu Accident Investigation 6 🗆 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29h. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) GM 30 F 2011

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

NOV 28

21202

84.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month William George Charles Breitenbach, III 19:40 P M Physician/ 2011 18. November Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore Randallstown Seasons Hospice Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours 214-05-3005 1 😾 M 2 🗆 F Director 94 30, 1916 Maryland Dec. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10a. State the Maryland Director 1 Yes 2 No be notified Halethorpe Baltimore MD 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number ò Funeral USA ms 23a c must be 21227 2745 Arbutus Avenue death with items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. . ∟ Yes 2 X No If Yes, Give Year o þ 1 Never Married 2 Married "natural", or and 2 should be filed within 72 hours after Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: 3 XWidowed 4 Divorced Completed al Hygiene.
Jother than "natura vent, the Medical E 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Health Care Electrician Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ethel Irene Zoeller and Mental F William Breitenbach Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 603 Claiborne Road, Stevensville Maryland 21666 Department of Health an Important: If item 27 is any injury or other travonce. Jerry Breitenbach-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Page 1 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery Nov.23,2011 Brooklyn Park Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home Inc. 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Inknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy funeral director, page 2 perform 2 🗌 No Yes 20 No 1 Tes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20X No 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes မ 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death Certificate: 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 24 hours after death Funeral Director: A the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check within 2 To the I only one) 29b. Signature

State Registrar

X DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year) NOV 28

2835

npleted cause of death (Item 23a) (Type, Print)

37 Leroy Bro		State of Maryland / Department	of Health and Mental I				
Physicia	n/	Registrar  1. Decedent's Name (First, Middle,Last)	of Death	Date of Dea     Month	Day Year		
al Examin	er	Robert Leroy Brooks, III  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	Novembe	r 20, 2011 0641 nrs		
		6680 Pirch Way	Elkridge		4c. County of Death Howard		
uneral irector		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24H Months Days Hours M		rth(MM/DD/YYYY) 9. Birthplace (State or Foreign		
	ŀ	220-13-4334 1 N 2 F 30 Yrs. Worths Days Hours Min. 03/2 Usual Residence of Decedent			/1981 Country)Maryland		
nd show any acc.		10a. State10b. County10c. City, Town or Location10d. Inside City LMarylandBaltimoreCity1 XYes 2					
tarylan 28a-f st l at onc		10e. Street and Number			Og. Citizen of What Country?		
3a or	ַבֿן	911 Coleridge Road	21229		United States		
rr death with the Maryland or items 23a or 28a-fah must be notified at onco Funeral Director		1 X Never Married 2 Married Armed Forces? If	as Decedent of Hispanic Origin? ( Yes, specify Cuban, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14. Race - American Indian, Black, White, etc.		
	DA Fri	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2X No specify:		Specify: White		
Exami		during r	nt's Usual Occupation (Give kind on nost of working life, DO NOT use re	f work done	16b. Kind of Business/Industry		
215-0036 be filed within 72 h ttal Hygieneked other than "n ent, the Medical E		Elementary/Secondary (0-12) College (1-4 or 5+)					
ygiene other	Completed	10 N/A Fo 17. Father's Name (First, Middle, Last)	od Delivery	ne (First, Middle, M	Food Industry Maiden Surname)		
irked	e n	Robert Leroy Brooks, Junior	Jo Anr	Jo Ann Mitzel			
and Me	]≏				nber, City or Town, State, Zip Code)		
Baltimore, MD oemit. Pages 1 and 2 sho Department of Health and important: If item 27 is njury or other traumati	ŀ		42 Clarenell Roa	ad, Balti Date	Imore, Maryland 21229  [20c. Location - City or Town, State		
t of H			ther place)		Glen Burnie		
artmer ortan	-	4 Donation 5 Other Specify:			UNERAL HOMES, INC.		
i i i o					Arbutus, Maryland 2122		
/sician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	the mode of dying, such as cardiac	or respiratory arre	est, shock, or heart Approximate Interval Between Onset and		
aminer Insit	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Last Chol and Quetiapine Intoxication  Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of):						
n and	3	M UNPENDED AMENDED 23a, 27, 28a-f, per me, g922 12-1-11 sm					
nding physici		IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery					
by the attending physician and ched for use as the burial - transit		23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day  4 Pregnant at time of death 5 Other (Specify)  9 Unknown					
by the	-	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?					
signed be det	3				2 No 3 Probably 4 ✔ Unknown		
LIVISION OF VIZIL RECORDS, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach edical Certification: To Be Completed by P					24b. Were autopsy findings available prior to completion of cause of		
			-	autops perform	med? death?		
		25. Was case referred to medical 26.Place of Death (Check only one)					
Physici r this or al direc	٤L	examiner?  1  Yes 2 No    Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other   4   Nursing Home 5   Residence 6   Other: Scene					
DIVISION OF The Hospital or Attending Planshin 24 hours after death.  To the Funceral Director: After completely filled in by the funeral ledical Certification; The funeral complete of the funeral c		27. Manner of Death  1 Natural 5 Pending (Month, Day, Year)  28a. Date of Injury (Month, Day, Year)  1 Natural 5 Pending Investigation of Injury (Month, Day, Year)  1 Yes 2 X No		28d. Describe how injury occurred unknown			
		2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  A Residence		28f. Location (Street and Number or Rural Route Number, City or Town, State) 6680 Pirch Way E1kridge, Md.			
within 24 hour To the Fune completely fill		29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
To con	2	and manner stated.			29d. Date signed (Month, Day, Year)		
		Carol Hallain O.C.M.E.		November 21, 2011			
\$	3	<ol> <li>Name and address of person who completed cause of death (Item 23a)</li> <li>Carol Allan, MD Assistant Medical Examiner 900 W. Balt</li> </ol>	timoro Stroot Dalkinson M	ID 24222			
	L	11. Date filed (Month, Day, Year) 32 Registrar's Signature	unore sueet, baltimore, M	ID 2 1223			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician/ Brown 7:50 an rnest Nov Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Manor Care Nursing Center Rosedale Age (In yrs. If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 1 № M 2 🗆 F Months Hours Min. 8 Md 219-58-6359 Director 4 Iune. Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò er than "natural", or items 23a or the Medical Examiner must be Funeral USA 410 W. 21201 Franklin St. Apt. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 ☐ No 5 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: Black Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other transmath. Elementary/Seconday (0-12) College (1-4 or 5+) Bocial Security Adm 4vrs Accountant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ပ Ernest Barnes Edith m. Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5411 Moravia Rd Baltimore, Md 21206 Withers Cannon/Brother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Valley Membrial Nov. 29,2011 Timonium, Md 4 Donation Other (Specify) Dulaney eral Service Licensee 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 F. PRESTON ST. BALTO. MD 21 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final varas cell carcinoma /hysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) 18 P sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 led by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Box in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Day Pregnant at time of death 9 Unknown P.O. signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an anemia has autopsy performe 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After work? 1 Yes 2 No iniury 5 Pending 1 Natural Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hour To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Vertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier R111615 11/21/11

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jennifes 31. Date filed (Month, Day, Year,

NOV 28 2011

Goldisbaraush

32. Registrar's Signature

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Benson

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21201

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Nov Day 22 2011 Busciglio Ella 12:27 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Arnold Futurecare Chesapeake 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Mir 233-44-8710 88 **Director** 1 □ M 2 🗗 F Yrs. Aug 30 1923 Usual Residence of Deceden or 28a-f show notified at 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Pasadena 1 Yes 2 No 10e. Street and Number 10f. Zip Code ㅎ 10g. Citizen of What Country? ms 23a or must be r Funeral 21122 USA 278 10th Street items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. event, the Medical Examiner Armed Forces Black, White, etc. ò þ 1 Never Married 2 Married Yes 2 No 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. "natural", Specify Completed 3 🔀 Widowed 4 🗌 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Lab. Tech medical marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Bandy Elizabeth Herbert traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Health tem 27 i grandson 2520 Ayr Ct. Crofton MD 21114 Tony M Busciglio Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Metro Crematory 11/25/11 Baltimore MD permit. 21. Signature of Funera 22. Name and Address of Facility Stallings Funeral Home P.A. 3111 Mountain Road Pasadena MD 21122 23a. Part 1. Enter the disease, or cor shock, or heart failure. List only ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest se on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ane a disease or condition Par Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): use as the burial-transi Cause (Disease or injury that initiated events . resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Year Pregnant at time of death signed by the ar Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed plnous been 24a. Was an Were autopsy findings available has page 2 autopsy prior to completion of cause of perform death? certificate 1 Yes 2 1 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other 2 2 1 Inpatient 2 ER/Outpatient 3 DOA me 5 Residence 6 Other (Specify, Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending hours after death, 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide the Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To time best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 6 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) 31. Date filed (Month State 2 8 Registrar

DHMH 17 Rev 06-2011

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death ent's Name (First, Middle, Last) 2. Date of Death Physician/ MUS nnie Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death PRINCE GEORGE'S GREENBELT 7710 MANDAN ROAD Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Director 251-96-7352 1 □ M 2**X** F 61 SEPT. 17 1950 SOUTH CAROLINA Usual Residence of Decedent items 23a or 28a-f show ner must be notified at with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🙀 Yes 2 🗌 No MD PRINCE GEORGE'S GREENBELT 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7710 MANDAN ROAD 20770 USA death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Examiner Armed Force ō by 1 Never Married 2 X Married 1 Yes If Yes, Give 2X No Baltimore, Maryland 21215-0036 nan "natural", e 1 Yes 2 No Specify: SpecifAFRICAN AMERICAN Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the INFORMATION SPECIALIST GOVERNMENT marked other Be 17. Father's Name (First, Middle, Last) th and Mental h 18. Mother's Name (First, Middle, Maiden Surname) မ JAMES OSBORNE PAULINE LONEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ye 1 and 2 s t of Health a If item 27 i EDWARD CURRY/HUSBAND 7710 MANDAN ROAD GREENBELT, MARYLAND 20770 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, HARMONY CEMETERY 11/26/11 LANDOVER, MARYLAND J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Se 22. Name and Address of Facility rvice Licenses 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the dis shock, or heart fail se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underl in Cause (Disease or injury Examine Due to (or as a consequence of): and I-transit that initiated events resulting in death) Last Due to (or as a consequence of): burial-1 physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the ast IF FEMALE nse Was deceud. in the past 12 montr 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 Fetal death Ectopic pregnancy Month Pregnant at time of death detached þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy performed? funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this uneral Director: Affer the fy filled in by the filled 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. The basis of examination and on the basis of examination and on the cause (s) and manner as stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and timpof certific

Registrar
DHMH 17 Rev 06-2011

State

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30. Name and address of person who completed cause of death (Item 23a) (Type,

8

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 \(\int\) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a Facility Name (if not institution give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** Howar +tospitu olumbia rs. last birthday) 9. Birthplace (State or Foreign Country) 8. Date of Birth Day, If Under 1 Year If Under 24 Hrs. **Funeral** 1 M 2 F Hours Director 28a-f show 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at Completed by Funeral Director 1 Yes 2 No umbia 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be 21044 items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ō 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify Klac 'natural", 3 ₩ Widowed 4 □ Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany njury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working Elementary/Seconday (0-12) College (1-4 or 5+) omesti Be 17. Father's Name (First, Middle, Last) is, Middle, Maiden S Mother's Name urname 19a. Informant's Name/Relationship (Type, Pfint) aughter ess (Street and Number or Rural Route Number, City or The Number, homas 20a. Method of Disposition 20b. Place of Disposition (Name of 1 M Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fundral Service icens**e**e 23a. Part 1. Ente e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Shock Physician/ disease or condition resulting in death) Medical Due to for as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by completed filled in by the funeral director, page 2 should be 1 Tes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c, Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred : After 1 injury 1 Natural 5 Pending Investigation M ☐ Accident within 24 hours after deal To the Funeral Director: 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge death occurred at the time date and place, and due to the cause(s) and manner stated. 1 Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARM OR 21 31. Date filed (Month, Day, Year) State 28 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2 Date of Death cedent's Name (First, Middle, Last, **Physician** 10:00 A M arrol lovember 23, 2011 /Medical 4c. County of Death Name (If not institution, give 4b. City, Town, or Location of Death **Examiner** Baltimore we uvivaton 8. Date of Birth 7-23-1939 If Under 24 Hrs. (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 38-5206 Months Hours Min 1 M 2 M F Yrs. **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show d other than "natural", or items 23a or 28a-f sho event, the Medical Examinar must be notified at Baltimore Yes 2 No Director W.D 10g. Citizen of What Country? 10e. Street and Mmber 21215 USA Tar Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? Race - American Indian Black, White, etc. 11. Marital Status Yes 2 **N**o filed within 72 hours after 1 Never Married Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify. Blac þ 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) n**g**ary (0-12) College (1-4or 5+) marked other 17 Father's Name (First. Mother's Name (First, Middle, Maider Middle Last 18. 1 and 2 should be fill Health and Mental H Hm 27 Is marked oth Informant's Name/Pelationship (Type. Print) Grand Rural Boute Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau Daughter 70 Baltimore, 20b. Place of Disposition (Name of cemetery, cramatory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12-1-11 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SPIN disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner WELLSIM if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical attending ph for use as the IE FEMALE ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Day Month Year 5 Other (specify) signed by the a P.O. I 1 □Yes 2 □No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown s peen s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy perform this certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 ☐ Pending investigation Natural Natural Hospital or Attendit n 24 hours after death. te Funeral Director: A Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Funer completely file Medical 🖆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number (VVVD 11264 2011

State Registrar

DHMH 17 Rev 1/2001

NOV 28 2011

31. Date filed (Month, Day, Year)

SMITH NE #203, BALTIMORE, MD 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nov Cuber 22 **Physician** Coulson 05:48 AM rank 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** | Months | Days | Hours | Min. | Min. | July 16,1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🛮 M 2 🗆 F Yrs 166-38-7842 16,1946 Pennsylvania **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linury or other traumatic event, the Medical Examiner must be notified at an once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director PA Montgomery Bryn Mawr 10e. Street and Number 10f, Zip-Code 10g. Citizen of What Country? 1100 Barberry Road Funeral 19010 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: à Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ 12 Banker Finance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank L. Coulson Ruth Auckett ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Miller Coulson - Wife 1100 Barberry Road, Bryn Mawr, PA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Buria 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) David's Churchyard 11-26-2011 Wayne, PA 21. Sig ature of Puneral Service Menses 22. Name and Address of Facility Chadwick & McKinney Funeral Home, 30 East Athens Avenue, Ardmore, PA 19003 emu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician lung goeno carcinon disease or condition resulting in death) /Medical Due to for as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed that initiated events use as the burial-tra resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physiciar Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the at 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page, 2 □ No certificate 1 ☐ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Inpatient 2 ER/Outpatient 3 DOA မှ After this 27. Manner of Death the funeral 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: or Attending (Month, Day 5 Pending investigation s after death. 2 Accident 1 🗌 Yes 2 🗌 No 3 Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only completely one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) RES-000 November 22, 2011

2

DHMH 17 Rev 1/2001

State Registrar 4940 Eastern Avenue, Baltimore, MD, 21224

address of person who completed cause of death (Item 23a) (Type, Print)

M.D

32. Registrar's Signature

Mesarwi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37482 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5:05 PM Grace Naomi Crumbacker 2011 Nov 18 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll Hospice Dove House Westminster 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 9-25-1915 Months Days Hours 213-09-5442 96 **Director** MD Usual Residence of Decedent r 28a-f show notified at 10a. State 10d. Inside City Limits 10c. City. Town or Location death with the Maryland Director Westminster 1 ☐ Yes 🞢 No Carroll MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important if flem 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be rooce. Funeral 51 Chase St. 21157 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: white Completed 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Book 9 Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Aaron J. Miller Nettie B. Wantz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chase St., Westminster, MD 21157 Donna M. Kibler-daughter 20c. Location - City or Town, State 20a. Method of Disposition 20h. Place of Disposition (Name of cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Kriders Cem. 11-22-11 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ORF Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence oi). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death 2 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of autopsv performed death? 1 Yes 2 Ho 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) INPATIENT 2 No မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at iniury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signatur 29d. Date signed (Month, completed cause of death (Item 23a) (Type, Print) DRF Kruter WESTMINSTER 44 19 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 24, 2011 5:27 A M Mark Edward Chance Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Towson Baltimore Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Year) 55 218-64-7406 Director 1 X M 2 🗆 F 2/27/1956 Maryland Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location at 10a. State 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 🗌 Yes 2 🗶 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6305 Mount Alto Ave. 21207 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Je filed within ... ental Hygiene. arked other than "natural", or ~~ent, the Medical Exam Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home Remodeling Sales 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ပ Joseph Ellwood Chance Dorothy Mildred Hoffman and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Holmes / Sister Nottingham, Maryland 21236 1 and 2 s of Health item 27 21 Sylvan Oak Way 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Serv. Corp. 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 

Burial 2 

Cremation 3 

Removal from State 11/28/2011 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 of Funeral Service Lic 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): as the burial attending physician Physician/Medical certificate be Box 68760 nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Day Pregnant at time of death 1 Yes 2 L 9 Unknown the Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe certificate has Yes 2 No 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 NO ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Pother (Specify) Howai Co within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Secritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cegtifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one d title of certifier 29b. Signature ap 29c License number 29d. Date signed (Month, Day, Year) D71040 MD

DHMH 17 Rev 06-201

State Registrar APATHI

31. Date filed (Month, Day, Year)

NOV 2 8 2011

SOFTE

NCO ARLES

30. Name and accress of person who completed cause of death (Item 23a) (Type, Print)

KUMAR

6701

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37484 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month -1/ reja Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Parkville Oak Crest If Under 1 Year If Under 24 Hrs Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2X F Country) Maryland Oct 16, Year 932 79 218**-**28-4068 **Director** Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2X No Lutherville MD Baltimore 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? by Funeral **USA** 21093 1706 Greenspring Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give Specify: white 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Zurich Insurance Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Catherine Zielinski Peter Baginski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1807 Campbell Road; Forest Hill, MD 21050 Mark Caro son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 
Removal from State 4 Donation Other (Specify) Hilltop Service Corp | 11/26/2011 Towson, MD 1050 York Road 22. Name and Address of Facility 21. Signature of Fun rel Sarice of MD 21204 Ruck Towson Funeral Home, Inc. Towson, 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause mat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnan 23d. Date of delivery Ectopic pregnancy for in the past 12 months' Other (specify) Pregnant at time of death signed by the at d be detached for g Unknown Unknown contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Onknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has birector, page 2 s autonsy death? perform 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) ျ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes Certificate: 28b. Time of 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation within 24 hours after deatl

To the Funeral Director:
completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 32. Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Year CARLEY MAYNARO CHARLES 1052 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 100-24-4816 Director 1 **X** M 2 □ F New York Usual Residence of Deced 78 8-18-1933 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Funeral Director notified 28a-f 1 X Yes 2 No Md Howard Clarksville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 ral", or items 23a or Examiner must be USA 21029 13487 Brighton Dam Rd 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. , 00 Completed by 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after ament of Health and Mental Hyglene.

Then 27 is marked other than "natural", or sure that if then 27 is marked other than "natural", the Medical Examin ury or other traumatic event, the Medical Examin 1 xx Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify. 3 Divorced 4 Divorced Year or Dates. Korean White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) mechanical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 contractor Dry Cleaning Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Ollie Wolfe Frank Carlev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13487 Brighton Dam Rd. Clarksville, Md 21029 Laura Carley
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If its any Injury or of 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/27/2011 Glen Burnie, Md Atlantic Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring Rd. Laurel, Md 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CLOSTRIDIUM DIFFICILE DAYS disease or condition ) Medical resulting in death) Due to (or as a consequence of): Examiner 5 DAYS TRACT URINARY INFECTION Sequentially list conditions, Examiner Due to (or as a consequence of). if any, leading to immedia cause. Enter Underlying 3 MONTHS as the burial-transi Cause (Disease or injury that initiated events STROKE Due to (or as a consequence of): resulting in death) Last attending physician for use as the burla Physician/Medical YEARS ARDIOMYO PATHY the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 24 hours after death.
Funeral Director: After thi etely filled in by the funeral. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the 29b. Signature and title of certifier

Calay-B. Navourally NOV 22, 2011 D005/119 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
UDAY BNANAUATY, MD INTENSIVIST, 5755 CEDAR LANE, COLUMBIA, MD 21044 31. Date filed (Month, Day)

DHMH 17 Rev 06-2011

Registrar

egistrar's Signatur

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a per fb 991 11-28-11 vt State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Crew Sr. Physician/ L. 18 2011 5:20a. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town or Location of Death Baltimore 4c. County of Death Examiner Future Care Nursing Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) g. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months 249-32-7582 1 1 Month, Day 85 SC Director Usual Residence of Decedent 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a State 10b. County 10d. Inside City Limits Examiner must be notified at Director Baltimore MD NA rew, John 1 XYes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 Funeral 3404 Ellamont Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 X Married Ď Baltimore, Maryland 21215-0036 Black 1 Yes 2 X No Specify 3 Widowed 4 Divorced Completed Year or Dates and Mental Hygiene.
is marked other than "naturaumatic event, the Medical" | 16b. Kind of Business Industry | Baltimore City | Public Schools 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 12th grade (0-12) College (1-4 or 5+) Superintendent 8+yrs Be 18. Mother's Name (First, Middle, Maiden Surname) **Lula Johnson** 17. Father's Name (First, Middle, Last) ပ John A. Crew 9a. Informant's Name/Relationship (Type, Print) ab. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3404 Ellamont Road, Baltimore, Md 21215 permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other to 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 11/26/2011 Pikesville, Md 4 Donation 5 Other (Specify) Druid Ridge 21. Sig lature Manager Andrew of Wellist 4300 Wabash Ave, of Funeral Service Licenses Baltimore, Md 21215 Approximate Interval Between Onset and Death 23a. Pait 1. Enter the disease, or complications that au shock, or heart failure. List only one cause on each aus of the death. Do not enter the mode of dying, such as cordiac or respiratory arrest, Immediate Cause (Final disease or condition Physician/ Medical resulting in death) we to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) physician and the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav signed by the a g Unknown Part/]I. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s autopsy performed? Yes 2 A No 1 Yes 2 No 25. Was case referred to medical director, 26. Place of Death (Check only one) Hospital ၉ 1 ☐ Yes 2 ✓ No 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral of 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VITE203 BALTIMOKE, SMITH AVE Merch 2835 31. Date filed (Month, Day, Ye State

Registrar

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 37487 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Cole 9:30a. M Icelon Berry 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Future Care Nursing 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours 214-20-9848 **Director** 1 🗆 M 2 🖺 F 01 12 24 NC 87 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene.
Important: If fiem 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director NA Baltimore MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21219 U.S.A. 12 North Mt. Olivet Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes. Give Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) House Wife Home 6th grade na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Walter Baker Mable Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7316 Inwood Ave, Catonsville, Md 21228 Sharon Robinson-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth once. 20c. Location - City or Town, State cemetery, crematory or other place) 11/25/2011 Baltimore, Md Baltimore National Funeral Service Licer 22. Name and Address of Facility March F/H West 4300 Wabash Av Baltimore, Md Ave, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ arrythemia disease or condition Cardiac minues Medical resulting in death) Due to (or as a consequence of) Examiner heartdiseuse Hypertensive 10425 Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury or as a consequence of physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burnal-transit multiple strokes 10428 that initiated events Due to (or as a consequence of): resulting in death) Last Seizures Physician/Medical 5420 Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Pregnant at time of death 4 Pregnant g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Decubitus vicers Diebeles me llitus 1 Yes 2 No 3 Probably 4 Unknown anoxic encephalopathy 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an multiple performed? 2 Ko pre umonie s 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital Other: ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work Accident 1 Tes 2 No Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D30494 11/23/2011 K DETALMO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DESAIMO Baltimore morkers 718 maiden Choic 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary Cromer Medical 9 2011 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Baltimore 4b. City, Town, or Location of Death Manor Care Nursing Home Catonsville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours 218-30-5329 Director Country) 1 □ M 2**X** F 79 01 32 09 WV Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location must be notified at Director 10d. Inside City Limits MD NA Baltimore 1 X Yes 2 No 10e. Street and Number items 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 2926 Arunah Ave 21216 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items, any injury or other traumatic event, the Medical Examiner musones. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 🔀 No If Yes, Give Year or Dates 1 Yes 2 No Specify. 3√2 Widowed 4 □ Divorced Completed Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) <u>12th grade</u> Culinary Specialist Super Pride na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Davis Price Annie Addison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Gode) 6213 Seton Hills Lane, Gwynn Oak, Md 21207 Lisa Outten-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/26/2011 Arbutus Memorial Arbutus, March F/H West mald c 4300 Wabash Ave, Baltimore, Md 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final METASTATIC GHSTRIC Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any local great framediate cause. Enter Underlying Examine Due to (or as a consequence or) Cause (Disease or injury that initiated events and use as the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicia. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ò in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Dav Year been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has ral director, page 2 autopsy performed? Yes 2 No 2 X No 1 🗌 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 X No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the I within 2 only one 3 Certifying Nurse Pragitioner: ny knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ertifie 29d. Date signed (Month, Day, Year) 10061765 2011 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 21229 WILLIAM AGE#307 State 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37489 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 4h **Physician** Month Year Paula Holloway Campbell Υ. 2011 /Medical November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hospital of Bathimore 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min Director <u> 265–53–9065</u> 51 20 09 60 FL Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits if than "natural", or items 23a or 28a-f showing the Medical Examination at the notified at MD NA Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2931 Marnat Road Apt F 21209 45 Faula Holloway Cample Baltimore, Maryland 21215-0036 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married 1 ☐Yes 2 If Yes, Give 1 ☐ Yes 2 No Specify: þ Specify: Black 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) New Psalmist 12th Grade (0-12) Baptist Church Liturgical Dancer 7 Is marked other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas L. Holloway Lelia M. Burden 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2931 Marnat Road Apt F, Baltiore, Md John Campbell-Husband 21209 permit. Pages 1 and 2 Department of Health Important: If Item 27 any Injury or other tr. once. Item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State On-Site 11/25/2011 Baltimore, Md 4 □ Donation 5 □ Other (Specify) 21. Sign ture of Funeral Service Licenses March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** omplishors disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≦ icate has been sig page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 又Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a Was an autopsy certificate Division of Vital 2. No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1▼Yes 2□No Certification: To this 1 Inpatient 2 ER/Outpatient 3 □ DOA funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Aftert 28h Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending hin 24 hours after death. the Funeral Director: A investigation 1 ☐ Yes 2 No the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certified 2

State Registrar 31. Date filed (/

10 V

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37490 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death よびず 2:45 AM Month Physician/ rome Medical 4b. City, Town, or Location of Death
Baltimore 4c. County of Death Facility Name (if not institution, give street and number) **Examiner** nevindate Gervatur Center N/A 6. Sex 1 🖾 M 2 🗌 F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpiac Country) MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 0<sup>3</sup>370571<sup>9</sup>22 89 Yrs. 214-12-0642 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1 X Yes 2 No N/ABALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 5608 WOODCREST AVENUE 21215 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 A Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) OWNER RESTAURANT Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ PINCUS COHEN RACHEL COHEN traumatic ge 1 and 2 should b nt of Health and Mer :: If item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5608 WOODCREST AVENUE, BALTIMORE, MD 21215 LILLIAN COHEN / WIFE other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery cremetory or other place)
ARLINGTON CEMETERY
CHIZUK AMUNO CONG. 1 A Burial 2 Cremation 3 Removal from State Department o Important: If any injury or ò 4 Donation 5 Other (Specify) BALTIMORE, MD 11/23/2011 22. Name and Address of Facility SOL LEVINSON & BROS., INC. of Funeral Service Cicens 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the disease, or con shock, or heart failure. List only aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate dications that Interval Retween one cause o Onset and Death Immediate Cause (Final ementia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Day in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? haava 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28b. Time of 28c. Injury at 28a. Date of injury 27. Manner of Death 28d. Describe how injury occurred Certificate: After (Month, Day, Year) injury 1 Natural 5 Pending 1 Yes 2 No s after dec. ral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours after
To the Funeral Dire
completed filled in b Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The design of the least of the only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier LO NO Mause 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2434 W. Belvedere Ave Ballimore MD21215 State 2 8 2011

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 2011 Physician/ ampbel 1905 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** eron altimore If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Months Hours Min. (Month, Day, Year) 1 □ M 2 💆 F **Director** 72 28a-f show 10b. County 10d. Inside City Limits at 10c, City, Town or Location Director must be notified 1 Yes 2 No timore 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? ö 23a Funeral deron Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Examiner Black, White, etc. o, 1 Never Married 2 Marr 3 Widowed 4 Divorced 2 Married g Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates. Specify "natural", Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore echnici Be 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last ည umpbell Zip Code) 2/244 Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date emetery, crematory or other place, Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Funeral Service Lic-MO 23a. Part 1. Enter the disease, or complications that cause d the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate et and De Immediate Cause (Final Physician/ wan disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami burial-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 □ Live Birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? or Month Day Year 4 Pregnant at time of death the detached 9 🗌 Unknown P.O. | signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed been sig Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 certificate To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 No Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 28b. Time of Certificate; 28d. Describe how injury occurred 1 Natural 2 Accident iniury 5  $\square$  Pending within 24 hours af er decth.

To the Funeral Director Af
completely filled in by the fu 2 No Investigation 2 Accidem
3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signer (Month, Day, Year) 2011 ise of death (Item 23a) (Type, Print) AVR Sute 203 Ba 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Division of Vital Records, P.O. Box 68760 124 hours atter geaun. Medical within 2.

To the F

complet Signature il 31. Date filed (Month, Day, Year, State Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2011 30 (Type, Print) Ave Suite 203 NOV 28 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lois Davis Nov. 2011 6:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Dunda1k 8179 Gray Haven Road . Social Security Numbe If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Director 243-80-1360 1 M 2 X Nov. 29,1948 62 North Carolina Usual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and It if item 27 is marked other than "natural", or items 23a or 28a-f sho usny or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD1 Yes 2X No Dunda1k Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 United States 8179 Gray Haven Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2XXNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White, etc. Lumbee American þ 1 Never Married 2. Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: Indian 1 ☐ Yes 2 XNo Specify: Completed 3 Widowed 4X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Sears Clerical 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Annie Locklear Fred Lowery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Sister) Carol Lowry 8179 Gray Haven Road Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I Important: If it any injury or of once. cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corp. 11/23/2011 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Julia 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a co equence of To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months? Day Year Pregnant at time of death be detached 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed 2 🗌 No 1 Tyes the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 1 🗌 Yes 2 [ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Desidence 6 Other (Specify, this 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred s after death. (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined building, etc. (Specify) within 24 hours a To the Funeral D Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 35761 15 11 30. Name and address of pe son who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Lucy Bevard Doty 11:06 PM 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Franklin osedale mare ospita Baltimore Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Day, Year) 2,1915 1 🗆 M 2 🛣 F Hours Min. April Director 213-12-9961 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore Edgemere 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2326 Lodge Forest Drive 21219 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black. White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 XNo Specify: 3 X Widowed 4 □ Divorced Specify: Year or Dates White 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Years Cook Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward C. Hunt Sarah R. Hvatt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benjamin F. Doty, Jr. (Son) 2326 Lodge Forest Drive Edgemere, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 M Burial 2 Cremation 3 Removal from State 11/23/2011 4 Donation 5 Other (Specify) Bel Air Mem. Gdns. Bel Air, Maryland 21. Signature Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) STIVE heart 92 Medical Due to ( a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Dav Year Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 욘 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation within 24 hours after deatl

To the Funeral Director;
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 11-20-2011 30. Name and address of per n who completed cause of eath (Item 23a) (Type, Print)

State

Registrar

DHMH 17 Rev 7/2009

Dr. Kamlun

31. Date filed (Month, Day, Year)

Auyeung

Registrar's Signature

Franklin

Samare Drive, Baltimore, MD 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 37495 = State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 1 24° 2011 Marie Ann Davis 6:00 AΜ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Timonium If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Davs 215-30-2478 **Director** 93 1 🗆 M 2 🗶 F 08-08-1918 Maryland Yrs 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Middle River Baltimore Maryland 1 🗌 Yes 2 ី No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 USA 7431 Greenbank Road 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Barbara Michal Emil Hermann Viertel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45449 Tippett Road Hollywood, Maryland 20636 Mr. William M. Davis - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Date 20c. Location - City or Town, State Most Holy Redeemer Cemetery 11-28-2011 Baltimore, Maryland 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ BRAIN CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year Pregnant at time of death Yes 2X No 9 Unknow 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 V No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 **X** No Other: 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 X Natural (Month, Day, Year) 5 Pending work 1 Tyes 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide within 24 hours after des To the Funeral Director completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) /25 2011 Oph 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registra

TRACIE MORGAN,

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NOVEMBER

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. ent's Name (First, 2. Date of Death **Physician** MOV 19 4:30 A /Medical 2011 Examiner Location of Death 4c. County of Death If Under 24 Hrs. Age (In vrs. last birthday 9. Birtho ace (State or Foreign **Funeral** Days 1 M 2 1 Director death with the Maryland 10a, State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f shov edical Examiner must be notified at Director 1 □ ¥es 2 □ No 10g/ Citizen of What Country? by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Marital Status 1 Never Married 2 Mamied Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of
life. DO NOT use retired),
AUM NISTRALI Medical 15. Decedent's Education (Specify only highest grade completed) Elementary Scondary (0-12) College (1-4or 5+) Be if item 27 is marke or other traumatic Health i HENIN 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 23a, Part1, Enter the disease. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac armthemias 15 minules /Medical Due to (or as a consequence of): Examiner heanh disause 1540 Hypertonsive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as a conse wence of U Demenner the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ned by the a 9□Unknown 9 Unknown Part 11. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performe rmed? 2 **□**No death? 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 2 1 Inpatient 2 ER/Outpatient 3□ DOA 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manper of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred Hospital or Attending P 24 hours after death. Funeral Director: After 28c. Injury at Work? 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D30494 \* DESHIM 11-28-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 716 maiden choice lone Baltimore mo 81828 K. DESHIND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 28 2011

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 20 | | For State Registrar 37497 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ernest Demby Sr. AM 2:25 NOV Medical 201 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1**火** M 2 □ F Months Hours Min (Month, Day, Year) Country) Director 217-38-7347 71 18 Usual Residence of Decedent shov 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits or 28a-f Severna Park 1 No MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21146 U.S.A. 194 McQuay Road items death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. and Mental Hygiene. is marked other than "natural", or i 1 Never Married 2 Married Completed by 72 hours after 1 Ly Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12)

12th grade College (1-4 or 5+) General Motors Assembly Man Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mae Franklin Wilmore Demby permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
194 McQuary Road, Severna, Md 21146 19a. Informant's Name/Relationship (Type, Print) Samuel Demby-Brother 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) ō injury ( 11/22/2011 Owings Mills, Md Garrison Forest 21. Signature ( Funeral Service Licensee 22. Name and Address of Facility
March FuneralHome West any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) 300 Wabash Ave, Baltimore, Approximate Interval Between Onset and Death -Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). -transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician Physician/Medical that the death certificate be 68760 the as for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day been signed by the a should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of or Attending Physician; The law page 2 s autopsy death? certificate 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 🔀 No Vital director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 1 🗌 Yes 2 XNo Other: 1 S Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di ot 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending work Division 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) M.D 2011 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greeve St. A.MBaltimore Kenneth 22 S. 21201 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37498 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 12:35 PM Dimpert November Daisy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Agnes Hospital Baltimore N/A If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 220-20-8131 Months Davs Hours (Month, Day, Year) **Director** 1 □ M 2 🟋 F 85 Yrs. June 8, 1926 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò item 27 is marked other than "natural", or items 23a o other traumatic event, the Medical Examiner must be Funeral be filed within 72 hours after death with USA 21227 1341 Poplar Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Force Black, White, etc. Completed by 1 Never Married 2 ☐ Married Yes 2 X No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🛛 No Specify: If Yes, Give 3 Nidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Automobile Supplies and Mental Hygie is marked other <u>Secretary</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lillian Marfield John C. Dimpert and 2 should the Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1871 Doctor Jack Road Conowingo Maryland 21918 Saundra G. Bratcher-Neice 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1; permit. Page 1 Department of I Important: If it ō 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) injury or Nov.16 2011 Glen Burnie Maryland Atlantic Crematory 22. Name and Address of Facility Amorose Funeral Home Inc 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) \_\_\_\_ in the past 12 months? for Month Day Year Pregnant at time of death ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed | d be def ð Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performe this certificate 1 Yes 2 No Yes 2 Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\simeg\) Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ္ 2 ER/Outpatient 3 DOA 1 Inpatient funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending of Funeral Director: All bletely filled in by the fu 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29b. Signature and 29c. License number erson who Name and address of

State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37499 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lois Ida Dulin 22,20**1**1 November 11:15 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 8620 Kelso Drive, Apt.B-301 Essex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland **Funeral** 8. Date of Birth 215-30-7260 Months Days Hours Jahn 26°,179°31 Director Usual Residence of Decedent or 28a-f show notified at 10a State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Essex 1 Yes 2 No 10f. Zip Code 21221 or than "natural", or items 23a or the Medical Examiner must be n 10e. Street and Number 10g. Citizen of What Country? U.S.A. Funeral 8620 Kelso Drive, Apt. B-301 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Secretary injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Oliver Dulin Ida Virginia Nabb 1 and 2 should b of Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claire Sadowski 1723 Glen Keith Blvd., Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ardent Cremation, Inc. //- 23-// Department of H Important: If ite any injury or otl 20c. Location - City or Town, State 1 🗆 Burial 2 X Cremation 3 🗆 Removal from State Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Farzullo Funeral Chapel, F.A. 21. Signature of Funeral Service Licensee 6009 Harford Road, Baltimore, Maryland 21214 Mar Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition im Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) Month 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate Yes 2 To Be 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Hospital: 2/ No Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 1 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 00167293 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6+30 HosgiMLDR BALTINGLE MO 21237 MO 32. Registrar's Signatu State NOV 28 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Physician 6:37PM avis ovember 2011 enne /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 1+1m6 If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day If Under 1 Year) 92 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 23 217-24-0953 1**Ø**M 2□F Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, it would be any injury or other traumatic event, it would be any injury or other traumatic event, it would be any once. 1 Yes 2 No Director 1+7 male 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21215 ants Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. 2 Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. 7mar 11 Hp. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition **B**urial 2 ☐ Cremation 3 Removal from State 30 | Baltimore 204 4 ☐ Donation → ☐ Other (Specify) Funeral Service 22. Name and Address of Facility owell ibe Heights Balto. 21201 4600 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are ach line. Immediate Cause (Final Hemor Vhors Physician rain disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner nevtensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Du t (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed To the Hospital or Attending Physician: The law requires that the ceam cerminate or waven, within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran. Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Nnknown 1 ☐ Yes 2 No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ NO 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 Mo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Man or of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number tenn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Recoville MO21205

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month

1838 Green

32. Registrar's